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At the Crossroads of TANF and Early Childhood Policy: The Impact of Devolution and Health Advocacy Networks on Progressive Policy Choices

Shannon Terry

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**AT THE CROSSROADS OF TANF AND EARLY CHILDHOOD
POLICY: THE IMPACT OF DEVOLUTION AND HEALTH
ADVOCACY NETWORKS ON PROGRESSIVE POLICY
CHOICES**

by

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B.A., Political Science, University of New Mexico, 1998

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
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The University of New Mexico
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DEDICATION

For those I love.

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ABSTRACT

Despite the conventional wisdom that U.S. social policies represent the emergence of a monolithic, racialized system of poverty governance that is purely punitive, there is increasing evidence that many states are repealing disciplinary social policy measures. In fact, several states are increasingly adopting enabling policies that are aimed at increasing public benefits to restore social equity among low-income families. These developments challenge current depictions of the landscape of the U.S. welfare state and they suggest that social and early childhood health policy choices may not simply emanate from a unified conservative social movement and racialized social structures. This dissertation fills a critical gap in the literature by examining the development of social welfare policies over time and it widens the scope of analysis to include early childhood health policies that are targeted towards low-income families. Challenging structural explanations of reform, the dissertation re-focuses our attention to the *politics* of social and health policy outcomes. Using a mixed methods design, this dissertation finds that conservative social movements have influenced both the development and repeal of stringent social policy measures such as family caps. I also find that evidenced based policymaking and the rise of the infant mental health movement played a key role in the development of the early childhood policy strategies adopted throughout the two-thousands. At the service delivery level, this logic has bred the adoption of multiple instrumental strategies in which health policy interventions are selectively invoked to accomplish predetermined goals. One key consequence has been that marginalized families are subjected to participating in vast surveillance systems that document their children's development, their emotional health, domestic violence and many other "risk" factors.

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Chapter 1: Introduction

The passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA)--commonly referred to as welfare reform--represents a watershed moment in the restructuring of the U.S. welfare state. After decades of confrontation between right wing conservatives, centrist politicians, and liberal policy experts, the conflict to overhaul welfare policy achieved bi-partisan cooperation that fulfilled President Clinton's promise to "end welfare as we know it." This federal legislation ended the federal entitlement to welfare or Aid to Families with Dependent Children (AFDC) and created Temporary Assistance for Needy Families (TANF). This new welfare regime devolved control of welfare policy to the states, it imposed a more restrictive set of time limited policies designed to move welfare recipients beyond dependency and into the workforce, and it called for a broad set of regulatory reforms that attempted to alleviate poverty through behavior modification strategies related to parenting, family formation and reproduction. While there is disagreement about the underlying political logic of the new American welfare regime, current research converges on one critical point. U.S. social policy represents the emergence of a system for governing the poor that is punitive and more muscular in its normative enforcement (Brown 1993; Cruikshank 1999; Mead and Beam 2006; Soss, Fording and Schram 2011). Policies have moved from an emphasis on rights and opportunities to a stance that increasingly relies on discipline and punishment to eliminate dependency in the U.S. Indeed, in an impressive array of research, Soss, Schram and Fording (2008; 2010; 2011) argue that several policy changes in social welfare policy at the national, state and local level reflect a coherent political logic rooted in neoliberalism and paternalism.

Current research has explained the propensity for states to adopt stringent welfare policies largely through the lens of race and social control. For instance, racial effects have become a standard explanation for disciplinary poverty governance in the U.S. The basic argument here is that welfare policy represents the reproduction of racial hierarchies in the U.S. and states adopt more punitive policy reforms when their population has large numbers of African American citizens (Soss, Fording and Schram 2008; 2010; 2011). Additionally, functionalist scholars suggest that welfare policies are mechanisms of social control (Piven and Cloward 1993; Wacquant 2009; 2010). Punitive welfare reforms emanate from the necessity of states to instill social order through regulating the behaviors of marginal populations (Suttles and Zald 1985; Piven and Cloward 1993).

Social Policy as Neoliberal

Contemporary poverty governance is often characterized as neoliberal because social policies are increasingly devolved to states, private, nonprofit service organizations deliver social services, and social policies are structured according to private market principles. Through contracting, decentralization and competitive enforcement systems, neoliberal reformers work to reinvent government in ways that mimic private markets (Soss, Fording and Schram 2011). Welfare reform, in particular, is characterized as neoliberal because it weakened federal responsibility for providing public assistance by stripping federal programs of their entitlement status and converting welfare to a state administered block grant. This change ended federal guarantees of welfare, placed a cap on total spending, and required that TANF undergo annual congressional budget reviews and re-authorization every five years. Welfare reform is neoliberal because it granted

states the authority to create their own regulatory policies related to work requirements and sanctions, it increased state discretion in eligibility determination and it gave the states substantial authority to decide how they spend their block grants.

In addition to embracing free market principles, critics of neoliberalism assert that social policy reforms also represent an ideological project (Brown 2003). For these critics, neoliberalism is more than a collection of economic policies aimed at decentralization and other market principles. The neoliberal agenda presumes that the individual begins life with a clean slate and competes on an even playing field. Risk events result from undesirable conditions that result from personal failures or irrational decisions (Smith 2007, 69). Thus, human rationality is not an ontological given, but a normative ideal that should be fostered by state institutions (Brown 2003).

As the state is hollowed out, so too are the social problems of the citizenry (Soss, Schram and Fording 2009; 2011). Through policy interventions such as vouchers and benefit policies that emphasize personal choice and responsibility, citizens become individual consumers that are free to pursue better outcomes by seeking goods from other providers through exit rather than pursuing collective action strategies to improve shared conditions (Soss, Schram and Fording 2011; Cruikshank 1999). Good citizenship entails pursuing individual volunteer work, charitable giving, virtuous service provision, and prudent work, consumption and investing (Wolin 2008).

Work enforcement, the best-known provision of welfare reform, represents these neoliberal ideological goals according to many analysts. To move women off welfare, the 1996 law intensified work requirements by adding stricter work rules and expanding workfare which requires that women on welfare without a job to work off their benefits

via performing unskilled tasks as volunteers in the social service and non-profit sector. Workfare also enforces these rules with punishment and deterrence. For instance, women face benefit reductions (sanctions) for minor rule violations (Abramovitz 2006). And perhaps most dramatically, for the first time in the history of welfare, Congress imposed a five-year lifetime limit on the receipt of benefits regardless of need. When women reach their five-year limit, they are expected to take a job.

Social Policy as Paternal

In general, paternalism refers to the government as a benign parent (Blackburn 2008, 270). Stemming from the metaphor of a father child relationship, the child, in this view, lacks the capacity to act in its best interest. The parent must use their legitimate authority to direct and supervise the child in ways that help him or her flourish. According to this approach, the government should play an active role in shaping citizen's behavior, and in particular, those who are poor and disadvantaged. Moving away from earlier configurations of social benefits that provide entitlements, analysts suggest that the new paternalism of the U.S. welfare state emphasizes civic obligations as a justification for behavioral expectations (Abramovitz 2006; Ben-Ishai 2012; Brown 2003; Murray 1993; Smith 2007; Soss, Schram and Fording 2011). For instance, welfare recipients must earn their cash benefits by participating in a variety of workfare activities such as professional development training; they are subjected to fertility and childrearing techniques that dissuade welfare mothers from reproducing additional children; and welfare reform policies suggest that paid work is a primary source of value in the vast majority of citizen's lives (Ben-Ishai 2012). In this way, paternalism is a project of civic incorporation that seeks to rehabilitate people such as the homeless, drug addicts, and

unmarried teen mothers who do not “display the minimal level of self control expected of decent citizens” (Wilson 1997, 340-41). Social policies are also paternal because they attempt to alleviate poverty through directive and supervisory means and they are premised on authority relationships based on unequal power status. Finally, paternalist policies presume that the poor lack the competence necessary to manage their affairs.

Conceptual Limitations

Current depictions of the U.S. welfare state provide important insights about the continuity and innovations encompassed by U.S. social policy. While these insights about change and continuity are valuable, these depictions are limited. Current depictions of U.S. welfare policies assume that decentralization is an ideological project that *always* depoliticizes social problems by defining them as matters of personal choice through the broad application of free market principles (Brown 2003). While deregulation and the devolution of social policy has certainly increased the influence of private actors in the policy process, I undertake a more neutral stance about whether deregulation and devolution necessarily produce policy interventions that are aimed solely at individual behavior change and are by nature punitive.

Instead, following the important work of Kimberly Morgan and Andrea Louise Campbell (2011), I suggest that the concept of delegated governance is a more useful framework to depict the *structural* logic underpinning of U.S. welfare policies. Delegated governance refers to a broader and older political phenomenon that has evolved since the post 1945 period. Put simply, it refers to the delegation of responsibility for publicly funded social welfare programs to non-state actors. Instead of bureaucratic agencies that assume full responsibility for distributing benefits or providing social services, collective

goals are increasingly realized through private entities that include nonprofit organizations and for-profit firms (Morgan and Campbell 2011, 19). The government may finance, regulate, and oversee social policies, but they do not necessarily provide direct provision of many social welfare benefits.¹

Delegation highlights that there is a deliberate attempt to assign responsibility for social welfare to non-state actors and it reflects the tendency to delegate political authority from the legislative branch to the administrative authorities that implement policies. These developments are important because they imply that instead of directly exerting authority through centralized, hierarchically organized public bureaucracies, the American state has frequently relied upon non-state actors to achieve its objectives. In recent decades, the acceleration of delegated governance has blurred the lines between public and private. However, rather than assuming that these structural developments are reducible to conservative forces and that they are always aligned with punitive policy measures, I suggest that these structural features are more likely to mediate the impact of a number of non-governmental actors and social movements on implementation policy choices at the state level. And in some cases, deregulation may even lead to progressive policies.

With respect to paternalism, there is also a tendency to equate paternal social policies with directive and punitive policies aimed at the poor. Part of this limitation stems from methodological shortcomings in current research. In particular, sinister conceptualizations of welfare reform often rely on ad-hoc qualitative analyses to support this interpretation. For example, Ben-Ishai (2012) presents a limited comparison of

¹ By contrast, in a situation of direct governance, government agencies directly provide benefits or services. Social Security is a situation of direct governance because benefits are directly administered by a federal agency.

workfare and teenage pregnancy policy discourses and concludes that both pregnancy prevention programs and workfare are rooted in misconceptions about intentionality among vulnerable, young mothers. While her analysis is logically coherent, she offers little explanation of how and why she selected these two areas nor does she state which policy sources she analyzes.

In addition to the get tough form of paternalism often advocated by social conservatives, there are other softer forms of paternalism advanced by critical figures in social and regulatory policy such as U.S. legal scholar, Cass Sunstein and behavioral economist, Richard Thaler (Thaler and Sunstein 2009). These softer paternal reformers advocate for policy interventions that shape the contexts in which people make decisions. These include changing social norms by influencing the ecology of decision making, entrenching habits, harnessing people's tendency to stick to their commitments, and cultivating willingness and motivation. Initiatives that fall under these softer paternal efforts include policy measures such as exercise promotion, anti-smoking campaigns, parenting programs, and substance abuse interventions that rely on counseling techniques designed to motivate cognitive and behavioral changes (Pykett 2012). Table 1 summarizes key differences between hard and soft paternalism.

Table 1: Soft and Hard Paternalism

	Soft Paternalism	Hard Paternalism
Definition	<p>Individuals are encouraged to adopt particular kinds of behavior that improve their own (and others) welfare.</p> <p>Policies facilitate more effective decisions making while ensuring that people should be free to opt out of specified arrangements if they choose to do so.</p>	<p>Policies designed to help people who behave irrationally and are not advancing their own interests, while interfering only minimally with people who behave rationally.</p>
Examples in Social and Health Policy	<p>Behaviorally Oriented Parenting Interventions</p> <p>Health Immunization Requirements</p> <p>School Attendance Requirements</p>	<p>Family Cap Policies</p> <p>Drug Testing Requirements</p>

Often referred to as ‘the real third’ way, this form of policy making has appealed to both liberals and conservatives alike. For example, progressive public health professionals in the U.S. have successfully implemented regulatory policies such as banning smoking in public places, they have used social marketing techniques to promote healthy lifestyles, and at the micro-level, public health bureaucrats continue to use behavioral change models to implement tertiary prevention programs aimed at curbing alcohol and substance abuse (Buchanan 2007). The key point here is that paternalism is not always as overtly disciplinary and marginalizing as the literature suggests. In fact, there is some evidence that even liberal professional policy actors committed to norms of social justice have advocated for some applications of paternal social policy reforms particularly with respect to health promotion. I suggest a more nuanced approach that is

premised less on ideal types by analyzing the tensions and potential contradictions of multiple soft and hard paternalist welfare reforms. I will return to this point shortly.

New Social Policy Developments

There is substantial evidence that many welfare policies are punitive, but several empirical puzzles emerge when we examine a broader range of social and health policies across time. First, the evidence suggests that it is difficult to reduce all policies under the rubric of discipline and punishment. For instance, and with respect to welfare, some regulations are intended to increase the educational attainment of mothers and their children and to increase welfare recipient's engagement with preventative medical care. Moreover, since welfare reform was federally mandated in 1996, many states have adopted enabling policies by diverting TANF funds to increase support for childcare vouchers among welfare recipients and some states have repealed some punitive policies altogether. Key among these repeals has been the reversal of family cap restrictions for recipients of TANF at the state level.²

Even more critical, several states are increasingly adopting seemingly *enabling* policies that are supposedly aimed at increasing public benefits to restore social equity among low-income families. Classic definitions posit that enabling policies are de-commodification regulations which stipulate that citizens can freely, and without potential loss of job, income or general welfare, opt out of work when they themselves consider it necessary (Esping-Anderson 1990). In short, enabling social policies utilize public benefits and services in ways that ensure that employment and working life are

² Family cap laws prohibit any increase in cash benefits when a newborn child is added to households covered by the Temporary Assistance to Needy Families (TANF) program. As a hard, paternalistic policy they were designed to reduce birth rates among poor, unmarried women (Camasso 2007; Camasso and Jagannathan 2009; Levin-Epstein 2003).

encompassed in the state's extension of citizen rights (Esping-Anderson 2009). In cross comparative analyses of welfare policies, enabling policies are typically universal laws that ensure paid maternity leave for all women and universal early child care provisions to name a few examples. While most social policies in the U.S. are not enabling in the purest sense because they mostly apply to the poorest segments of society, policies such as child care subsidies and universal pre-school education have been shown to improve the social position and life chances of poor women and their children (Ermisch, Jantti and Smeeding 2012; Ben-Ishai 2012).

Indeed, growing support for early childhood education and health policies arguably represents a new constellation of social policies that include a mix of behavioral, individual level interventions while simultaneously working to improve social and health equity among poor, vulnerable populations. Specifically, beginning in the late nineties and moving into the two-thousands, federal policy makers have increasingly invested in early childhood education and health intervention policies that are designed to reduce the transmission of socioeconomic disadvantage from parents to children. For example, the federal government has increased federal investments in increasing child care subsidies, promoted universal preschool education, and increased funding for home visitation interventions throughout the states. This growing network of think tanks, philanthropic organizations, public bureaucracies such as the Maternal and Child Health Bureau (MCHB), and elected policy officials have explicitly adopted a perspective which suggests the important role of early life events in shaping an individual's health trajectory across the lifespan (Fine and Kotelchuck 2010; Halfon 2009; Pies, Parthasarathy, Kotelchuck, Lu 2009; Shonkoff 2009). This life course perspective suggests "that there

are critical periods of growth and development, not just in utero and in infancy, but also during childhood and adolescence, when environmental exposures do more damage to health and long-term health potential than they would at other times” (World Health Organization 2000, 4).

Unlike the more stringent rhetoric embedded in the social welfare policy of the two thousands, this new early childhood health and education policy agenda suggests that the interplay of risk and protective factors, such as socioeconomic stress, toxic environmental exposures, health behaviors, stress and nutrition are the underlying causes of persistent inequalities in health and education. Veering away from suggesting that persistent poverty and poor educational outcomes reflect bad individual choices, this policy agenda suggests that socio-economic conditions throughout the life course shape adult health and disease risk. According to the official agenda of the Maternal Child Health Bureau, early childhood policies reflect the idea that “each life state influences the next, and that social, economic, and neighborhood environments across the life course have a profound impact on individual and community health” (Fine and Kotelchuck 2010, 3). *These social and health policy developments challenge current depictions of the landscape of the U.S. welfare state as purely punitive, and they suggest that early childhood health policy choices may not simply emanate from a unified, conservative social movement and racialized social structures.*

My dissertation contributes to our understanding of both the timing and the content of these federal and state policy choices in several ways. First, the repeal of some measures suggests that punitive social welfare policies may not simply emanate from unified, racially biased, neoconservative social forces. Indeed, racial bias and social

control theories provide convincing evidence that states with high concentrations of Blacks implement stringent welfare reforms, but these studies only test the impact of these factors on punitive welfare policies. This is consequential because both social control and racial theories are premised on the idea that negative racial images and coercive states are responsible for get-tough measures. But, if some policy choices are enabling or representative of soft paternalism, these theories do not offer any rationale for the adoption of these more progressive policy measures. Moreover, they cannot account for reversals in punitive reforms such as state decisions to rescind the family cap in more recent years.

Missing from the literature is an exploration of the role that health social movements, activist social welfare bureaucracies and the non-profit social service sector play in influencing state social policy choices. My dissertation contributes to our understanding of both adoption and content of state social policy choices by re-focusing our attention on the role that *political actors* play in state and federal decisions to adopt social policy reforms. I accomplish this in two primary ways. In the first part of the dissertation, I test the impact of progressive and punitive social movements on the adoption and repeal of family caps. Analyzing the timing of the passage and repeal of family caps is critical because the current literature is pessimistic about the possibility of progressive counter-mobilization efforts against a U.S welfare regime that is characterized as fundamentally punitive and disciplinary.

In the second part of the dissertation, I widen the scope of analysis to include an investigation of the development of early childhood policies that are primarily targeted towards low-income families in the United States. Indeed, early childhood health and

education policy has emerged as an important anti-poverty policy agenda over the last 15 years. In a deregulated environment that was precipitated by welfare reform 20 years ago, social and health policy advocates have leveraged research and diffused governance structures to pass seemingly enabling policies such as universal pre-k and expanded access to childcare credits for working parents. Home visitation, in particular, has become a popular strategy to increase social support and to bolster social rights.³ Indeed, federal policy makers, private think tanks, and policy makers have cited home visitation as strategy that can mitigate the impact of poverty on poor health outcomes and poor educational attainment among marginalized citizens in the U.S. The expansion of these progressive reforms not only suggests that social policy is shifting back towards enabling measures, but it provides fertile ground to examine whether the rhetoric attached to these policies aligns with the actual content and practices of home visitation.

In chapter 3, using home visitation as a focal point, this chapter traces the emergence of an early childhood policy network dating back to the progressive era; it uncovers the emerging policy narratives that characterize the field, and it leverages interview data to explore the institutionalization of these discursive frameworks, revealing the key mechanisms of the practice of home visitation in New Mexico. In chapter 4, I examine the implementation of home visitation intervention strategies in New Mexico. This analysis explores whether early childhood policy makers and interventionists conform to a paternalistic logic to reduce educational and health disparities among low-income families. The first stage of the analysis maps how a

³ Home visiting is a voluntary health and education intervention in which visitors provide health check-ups and referrals, parenting advice, and guidance navigating other social services. Home visitation is fairly invasive. Home visitors typically meet with caregivers once per week and continue until the baby reaches age two, and some programs continue until the child completes kindergarten.

private, faith based home visitation program creates organizational strategies ranging from clinically based behavioral modification schemes to employing community empowerment approaches to deliver home visitation services and to advocated for poverty reduction in the state. This chapter explores the tensions between constructing home visiting policies that advocate for the delivery of highly clinical services to mitigate social ills with community based advocacy strategies that are embedded in the praxis of social justice and community empowerment.

Methodological Innovations

To widen the scope of inquiry about social service provision in the U.S., I implemented a parallel, mixed methods design from conception to analysis (Green, Caracelli and Graham 1989). The intent was to give equal weight to quantitative and qualitative analyses in order to unpack the factors contributing to the evolution and landscape of social welfare and health policies over time. To test my theoretical expectations in chapter 1, I triangulated historical political analysis with quantitative event history analysis to understand the evolution of family cap policy over time. For the quantitative analysis, I created an original pooled time series data set that captures welfare and childcare policies across the U.S. states from 1990-2010. I created original measures of the strength of health and social policy networks to test the impact of political actors on the adoption and repeal of family caps. The data came from a variety of sources including the U.S. census, the U.S. Department of Health and Human Services, the Urban Institute, the Encyclopedia of Associations, the Welfare Rules Database, the Guttmacher Institute, the National Center for Charitable Statistics, the National Conference on State Legislators, the Center for Law and Social Policy, the

Glenmary Institute and several others. Using event history analysis, I contribute to the literature on welfare policy reform by testing the timing of adoption and repeal of family caps. For the qualitative component, I used process tracing to explore how divisions among fiscal and social conservatives contributed to the repeal of this punitive welfare policy measure.

In chapters 3 and 4, I employed and immersive ethnography to study the politics of early childhood and home visitation at the both the federal and state level. Political ethnography, as a method, is used to study culture (conceived as meaning systems) or other aspects of the social world including the economy, politics and social structure (Schatz 2013). For the purposes of this study, I utilized ethnography to gain a deeper immersion into the world of health and social policy making and social service delivery. This approach allowed me to understand how ideas about the underlying logic of social problems influence the policy solutions advanced by the early childhood policy network. This method is also advantageous for my research because it does not offer just a simple snapshot of decisions at one point in time. Rather, it allowed for the specification of the mechanisms of change because it captures the dynamism in the reproduction and transformation of policy decision-making.

I utilized several data sources and fresh analytical techniques for this stage of the analysis. The data sources include interviews, focus groups, participant observation, and photography. The ethnographic work for this chapter took place in several stages over two years from 2013-2015 with the generous support and collaboration with the Robert Wood Johnson Center for Health Policy at UNM (RWJF), the Institute for Social Research at UNM (ISR), the Center for Education and Policy Research at UNM (CEPR),

and the National Institute of Health (NIH). In the first stage of the ethnography, I identified key actors in the federal early childhood policy issue network. Based on this preliminary analysis, I collected over 40 policy briefs, white papers, and documents from these sources for the narrative document analysis. I also planned and participated in a national conference on emerging approaches in Early Childhood Education and Health policy sponsored by the Robert Wood Johnson Center for Health Policy in April 2014. This conference brought in leading research experts, policy analysts and policy makers in the early childhood policy arena. The conference provided an excellent opportunity for me to serve as an active participant observer to see firsthand, up close and personal, how the science of early childhood intervention has played a profound role in policy development at the national level.

In the second stage of ethnography, I worked and conducted extensive field research in the realm of home visitation policy in New Mexico. As an extern with CEPR, I worked closely with Dr. Samuel Howarth and the New Mexico Children Youth and Families Department to assist in a cost analysis for state run home visitation programs. Through this process, I learned about the politics and policy making of public and private home visitation and I gathered crucial information about the wide variation in home visitation models implemented throughout the state. I built relationships with state bureaucrats and policy makers, private advocacy organizations, research think tanks and with home visitation providers. This work provided ample background information and exposure to the struggles between evidence based approaches to home visitation and community based perspectives; conflicts between urban and rural conceptions of poverty governance; and the reciprocal relationships between public agencies and not-for profit

home visitation providers across the state.

Next, I worked with the Institute for Social Research for over a year and a half conducting an organizational ethnography of the largest private, home visitation provider in New Mexico and the country. With the approval of Dr. Paul Guerin and a local home visitation agency, I was able to study the practice of home visitation in collaboration with a larger fidelity study for a local home visitation provider. With their permission, I spent over 100 hours participating in staff meetings; conducting focus groups and interviews with staff members; and I observed 39 home visits. The data for chapter 4 come from this phase of the research and each entity approved the use of this data.

Finally, this research emanated from a broader National Institute of Health funded pilot project that analyzes the ways that home visitation programs in the state of New Mexico variously construct systems of social support and promote community empowerment to improve school readiness. Under the mentorship of Mala Htun (Principal Investigator), the research team used participant observations, ecological case studies, interviews, photo ethnography, and focus groups to compare and contrast variations in the actual practices of home visitation in rural and urban areas in New Mexico. The interview data from chapter 3 come from this phase of the collaborative research and the PI has approved the use of this data. Lastly, to protect the confidentiality of the home visitation agencies and home visitation participants, I use pseudonyms to discuss all of the results in chapters 3 and 4.

Why Study Home Visitation in New Mexico?

Poverty and Race in New Mexico

New Mexico provides an excellent setting to study the implementation of home

visitation policies for many reasons. Poverty is a part of the fabric of everyday life in New Mexico. In 2010, 47% of infants were born into poverty (their families earned less than 100 percent than FPL) and 22% were born into low-income families earning less than 235% FPL (U.S Census 2012). With an overall population of only 2.1 million people and a large geographic size, the conditions of poverty are decidedly different compared to dense, urban settings. For example, some counties are sparsely populated with as little as eight people living per square mile while Albuquerque, the state's largest metropolitan area, is home to 907,301 residents (U.S. Census 2015). Most studies of social welfare policy have used urban settings to explore the mechanisms of poverty governance in the U.S. I add to the literature by extending the analysis to a poor, rural state.

New Mexico is also a majority-minority state with 47% of the population comprising Latinos and 10.6% of the population comprising Native Americans. Current empirical applications of the dynamics of the U.S. welfare state demonstrate that policy adoption and punitive policies are shaped by anti-Black racisms. While there is sufficient evidence to support these claims, these findings are largely premised upon a black/white dichotomy of racial relations. This does not accurately reflect the ethno-racial politics of several regions within the U.S. The sociopolitical relations that constitute "Latino" groups have created very different forms of marginalization depending on the national origin group, the region, the political economy of a local state or city, and the broader context of political incorporation (DeGenova 2003, 2004; Kim 2003). In New Mexico, Latinos comprise those who have lived in the state for generations and trace their lineage to Spain and more recent Mexican immigrants who are new to the state.

In the southwest, Barrera (1979), and Gomez (2007) demonstrate that both U.S and Spanish colonialism have played a central role in constituting Mexican Americans as a marginalized group in that region.⁴ In particular, they suggest that through a constellation of factors including legal institutions, land grant distributions, labor market patterns and residential segregation, low income Mexicans and local indigenous groups have occupied lower social status compared to land owning residents who claim Spanish heritage. In this way, New Mexico provides an ideal setting to examine poverty governance in a setting that represents Latinos and their internal complexities among the fastest growing group in the U.S.

Health and Educational Disparities in New Mexico

From remote native communities that live in federally designated reservation areas to urban areas like Albuquerque, children's health disparities are among the worst in the country, as evidenced by the state's 2013 ranking as 50th in overall child wellbeing (Annie E. Casey Foundation 2013). Some of the most compelling data reveal that, compared to whites, NM Latino, Black, and Native American children are more likely to have persistently poor developmental outcomes and are less ready to succeed in early education. For example, attending high quality preschool and pre-kindergarten is essential for raising school performance. It multiplies the effects of later interventions by narrowing early achievement gaps and ensuring that children are fully prepared to learn and thrive academically, physically, socially, and emotionally. For example, long term follow-up from randomized control trials and quasi-experimental studies show that high quality early intervention programs reduce gaps in educational achievement and improve

⁴ For Gomez, race and ethnicity overlap in important ways, but Gomez employs the term "race" to emphasize how others often assign group membership whereas members of an ethnic group choose their ethnicity.

adult outcomes, including teenage pregnancy, welfare dependency, arrest, and earnings (Arnold and Doctoroff 2003; Campbell and Morgan 2002). Between 2009-2011, 67% of NM children below 200% of the federal poverty line were not enrolled in preschool, compared to 55% of those children at or above 200% (Annie E. Casey Foundation 2013). In 2012, only 35% of Hispanic children and 37% of Black children were enrolled in preschool compared to 47% of Native Americans and 45% of Non-Hispanic whites (Annie E. Casey Foundation 2013). Moreover, reading proficiency by third grade is the most important predictor of high school graduation and career success (Gray and McCormick 2005). In 2013, 83% of Hispanic, 93% of American Indian, and 76% of Black fourth graders in New Mexico scored below proficient reading levels compared to 62% of White children, revealing significant racial and ethnic gaps in reading proficiency (Hernandez 2011).

The Early Childhood Policy Network in New Mexico

Given these troubling statistics, New Mexico has become a federal target for many public and private investments in early childhood education and health equity policy interventions. In 2008, the Kellogg Foundation selected New Mexico as one of five states to receive targeted funding and in 2012 it opened a regional field office in the state. This private foundation has invested over \$22 million dollars in multiple interventions and community based efforts in four counties and across Native American communities. Consistent with the foundation's mission, these funding efforts have supported efforts to serve the needs of children including healthy access to food, improving breastfeeding relationships between mothers and their children, and by expanding early childhood education in the state with an emphasis on supporting a

variety of home visitation programs (Interview August 2015). As early childhood policy has emerged on the statewide policy agenda, three local foundations have also elected to combine their efforts and resources to support evidence based home visitation and early childhood education throughout the state (Interview August 2015).

Perhaps most critically, advocacy organizations, local community providers and several members of the state legislature have called for the state to leverage its Permanent Land Grant Education Fund to support a large expansion of child care subsidies, universal pre-kindergarten education and home visitation as well. Leveraging these funds to support early childhood policy interventions has become an increasingly polarizing issue between Democrats and Republicans. While there is bipartisan support for policy solutions that intervene early in the lives of children, Republicans increasingly oppose using the Land Grant Permanent Education Fund to increase early childhood policies in the state.

Home Visitation Programs in New Mexico

Specific to home visitation, New Mexico has also been a pivotal target of federal efforts to expand evidenced based models of home visitation dating back to 2008 when then President Bush began these early efforts. In fact, NM became one of a handful of states that was targeted for expanding home visitation due to its extreme poverty and poor outcomes associated with health and education among its large Latino population.

The New Mexico early childhood policy network has capitalized on some of the advances that focus on the broader context in which families raise children by emerging as a national leader in promoting policies that support early childhood development. Both government agencies and non-profit organizations in New Mexico have built a large and

impressive system of home visitation, with public funding alone increasing from \$500,000 in 2006 to \$8,451,800 in 2014. In 2013, the legislative session saw passage of the New Mexico Home Visiting Accountability Act (SB365), which defined the Home Visiting System, established a common framework for service delivery and accountability across all programs, and outlined expectations for annual reporting of outcomes. Building on past early childhood system-building efforts in the state, the law codified efforts initiated by a policy issue network that includes business leaders, state officials, regulatory bodies, and advocacy organizations dating back to the 1980s.

Linked primarily by their shared interest in improving child health outcomes and school readiness, this group of highly informed policy advocates plays a key and ongoing role in circulating data, participating in and facilitating policy roundtables, and drafting legislation to support the creation of an efficient and effective continuum of care for early childhood in the state. Yet, rather than adopt a single model of home visitation, the New Mexico Home Visiting System promotes community-specific home visiting programs that are responsive to their communities' unique cultural and linguistic heritage, and that respond to the myriad needs of New Mexico's children beyond the restrictions of some nationally-recognized programs.

Coordinated by a variety of governmental and non-governmental entities, home visitation programs vary on several dimensions, including whether the policy is universal or targeted; generalized or specialized; whether it involves nurses as home visitors or paraprofessionals; whether it is evidence-based or community-based, and whether it is hospital- or community-based. This variation is critical because it allows me to compare the practices of evidence based verses community based programs. In sum, New Mexico

is an important case study to explore the institutional development of home visitation policy because there has been a large investment in using home visitation as a strategy to mitigate the impacts of poverty on maternal and child life circumstances.

Why Should We Study the Underlying Logic of U.S Social Policies?

Building on comparative studies of social welfare provision, I suggest that understanding the meaning and development of social policies is critical because policy designs contribute to how we define social and political citizenship, they structure the nature of political and social mobilization, and they organize the exercise of political authority within society (Ingram and Schneider 2005; Morgan and Campbell 2011; Pierson 2004; Soss, Hacker and Mettler 2007). Similarly, and operating from a comparative perspective, Esping-Anderson (2002; 2009) theorizes that while the concept of social citizenship constitutes the core idea of a welfare state, the relationship between how governance affects citizenship and social class has been neglected theoretically and empirically (see also Ingram and Schneider 1995 and Mettler 1998 for a discussion in the context of U.S social policy). For Esping-Andersen, the welfare state is not just a mechanism that intervenes in and possibly corrects the structure of inequality in a given society. It, in its own right, is an active force in the ordering of social relations and it has the potential to promote social dualisms by punishing and stigmatizing recipients or by promoting an equality of status between the poor and middle classes through enabling policies that are universal, irrespective of class or market position. In short, understanding the meaning of social policy design(s) is particularly important because qualitatively different arrangements between the state, market and family are likely to produce different long term outcomes associated with health, poverty and the overall

status of women and children. In the pages that follow, I critically interrogate how newer forms of poverty governance operate in line with social justice and the extent to which they carry out democratic values that enable vulnerable people and communities to increase gain mastery over their lives and the lives of their communities.

Chapter 2: The Politics of Family Caps

Since the early 1990s, almost half of U.S. states have adopted “family cap” policies to discourage welfare recipients from giving birth to children while receiving public assistance. The family cap deviates from welfare under the Aid to Families with Dependent Children (AFDC) program when benefits were determined by family size—regardless of when children were conceived. Instead, family cap laws prohibit any increase in cash benefits when a newborn child is added to households covered by the Temporary Assistance to Needy Families (TANF) program. Family caps are not federally mandated through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PROWRA) or the 2005 reauthorization of Temporary Assistance for Needy Families (TANF). Instead, states have the option to implement this regulation. To date, 24 states have adopted family caps, and, of these states, 11 implemented their policy through waivers prior to the passage of PROWRA in 1996. Since 2003, no additional states have adopted the reform.

Most critically, and in an unexpected turn of events, 7 adopters *dropped the policy altogether*. For example, in 2002 Maryland began allowing counties to opt out of the family cap, and all counties chose to do so before 2004. In 2003, Illinois began phasing out its child exclusion provision and terminated the family cap policy in 2007. In addition to policy reversals, there have been a number of successful legal challenges to the family cap. These challenges resulted in major modifications to the law in states where family caps still exist. For instance, in Nebraska, the state’s highest court stopped the implementation of the family cap policy for certain classes of parents with disabilities. In California and Indiana, the courts ruled that capped children have the right

to child support assignments regardless of the timing of their birth. Compared to other welfare policies, family cap laws have changed considerably over time, providing a fertile context to explore the political factors that influence state policy choices.

Amidst these political struggles, only a handful of studies examine the factors that lead to state adoption, and I am unaware of any studies that analyze the determinants of the repeals of this controversial policy (Fellowes and Rowe 2004; Soss et al. 2001). With respect to adoptions, Soss et al. (2001) present compelling evidence that in 1996, states with a higher proportion of African Americans on TANF were more likely to adopt family cap provisions, to enforce stricter time limits on welfare, and to enforce stricter sanctions compared to states with high proportions of whites. They posit that these observed patterns are associated with the degree of policy-relevant contrast in policy actors' perceptions of racial groups (Soss, Fording and Schram 2011). State policy choices reflect differences in policy makers' mental maps of recipients. Maps are a function of prevailing cultural stereotypes of racial groups, the extent to which policy actors hold these stereotypes, and the presence or absence of stereotype-consistent cues (Soss et al. 2001, 79). To date, racial bias has become a common explanation for this punitive turn in social policy

While the impact of racial factors on punitive reforms is robust, previous scholarship has tested the impact factors such as race and morality politics using cross sectional analyses over one year (Fellowes and Rowe 2004; Soss et al. 2001). Studying a single policy at discrete moments in time carries the assumption that the determinants of social welfare policies are constant. This method potentially overinflates the substantive effects of racial bias and morality politics and ignores the dynamics of political struggle. I

add to this literature by 1) using a mixed methods approach to trace the political developments surrounding family caps and repeals, 2) by examining how outcomes reflect political mobilization and counter-mobilization between women's public health activists and conservative social movements, and 3) by testing the determinants of adoption and repeal of family caps with discrete time event history analysis tracking both adoptions and repeals from 1992-2010.

In part I of the chapter, I describe patterns in family cap adoptions and repeals and review the current literature on punitive social welfare policies. In part II, I trace the historical development of family caps by highlighting how the interplay between the politics of illegitimacy, the women's health movement, and the anti-abortion movement influenced the development of family caps and repeals. In part III, I depart from the inductive narrative to propose some general theoretical expectations based on social movement theory and the political context. Finally, in part IV, I conclude by analyzing adoption and repeals through discrete event history analysis and by discussing these findings in conjunction with the historical analysis.

A key innovation of this chapter is that I triangulate historical political analysis with quantitative event history analysis to understand the evolution of family caps. A principal strength of this approach is that it refocuses our attention on the political dynamics of social policy reforms over time. Analyzing family cap policy processes is also crucial because a handful of states have rescinded this policy altogether. This is intriguing because the literature paints a bleak picture about the possibility of counter-mobilization against a new welfare regime that is characterized as fundamentally punitive and disciplinary. Instead, the repeal of family caps suggests that political agents can

successfully revoke punitive policy measures. This chapter represents the next iteration of research on the development of the punitive social welfare state. I refocus our attention on political agency by testing how political actors and the political context influence the adoptions and repeals of perhaps the most symbolically racist (Gilens 1996; 2009; Hancock 2004) and punitive reforms in the new welfare era in the United States.

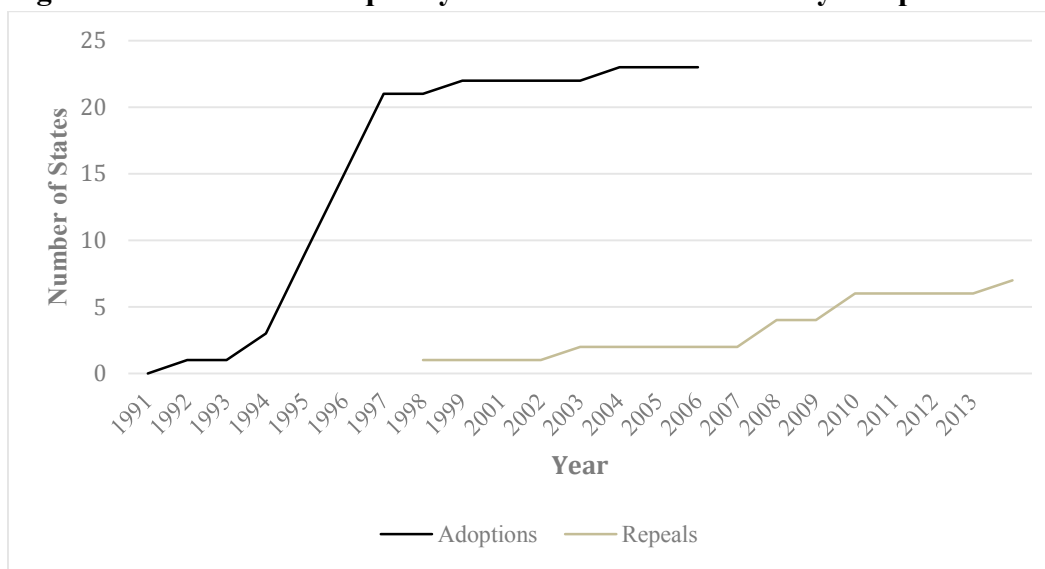
The Adoption and Repeal of Family Caps

The family cap is designed to reduce birth rates among poor, unmarried women (Camasso 2007; Camasso and Jagannathan 2009; Levin-Epstein 2003). Proponents of the measure offer several key rationales to justify this controversial policy. Fiscal conservatives suggest that caps effectively diminish the fertility of welfare recipients by offering economic incentives for parents to abstain from intercourse or to increase contraceptive practices while receiving assistance. Others contend that family cap laws serve the critical purpose of reducing illegitimate childbearing. For instance, in the early nineties, Charles Murray declared that the cap would have a number of healthy effects. “It will lead to many young women who shouldn’t be mothers to place their babies for adoption. This is good. It will lead others, watching what happens to their sisters, to take steps not to get pregnant. This is also good. Many others will get abortions. Whether this is good or bad depends on what one thinks of abortion” (Murray 1993, A14). By discouraging women on TANF from having more children that they cannot support financially, the presumption is that family cap laws will decrease the incidence of out-of-wedlock births among welfare recipients. In this way, family cap laws are a mechanism to reinforce the idea that marriage and two parent families promote stability and personal responsibility among welfare recipients (Gastly 2004). For social conservatives, family

cap policies present an alternative to contraceptive use with the added benefit of decreasing dependency on public institutions among the undesirable poor.

Opponents of the family cap suggest that family caps produce perverse policy effects. For instance, some suggest that caps may actually increase abortion rates among welfare recipients because mothers who conceive while receiving cash assistance may feel compelled to terminate their pregnancy for financial reasons (Cezenave and Neubeck 2001; Roberts 1997). Poverty advocates argue that family caps are likely to compromise the well-being of children by denying material benefits to these members of the family and they may actually increase poverty rates (Levin-Epstein 2003). These advocates also argue that even if employed families do not receive direct salary increases when a child is born, tax policies effectively subsidize the birth of additional children in working families by allowing working families to claim variety of tax credits. For these groups, family caps place undue financial burdens on vulnerable families.

Under the Aid to Families with Dependent Children (AFDC) program (the predecessor program to TANF), states played a prominent role in experimenting with a variety of reform efforts that eventually culminated in the federal legislation that effectively ended “welfare as we know it.” Family caps represent a key example of these state-led reform efforts. Figure 1 displays the cumulative frequency distributions for adopts and repeals of family cap policies. New Jersey was the first state to experiment with this reform in 1992, and Minnesota was the last state to adopt in 2003. These cumulative frequency distributions also show that half of the states that adopted family caps implemented them prior to the passage of PRWORA in 1996 through a federal waiver program.

Figure 1: Cumulative Frequency Distribution of State Policy Adoptions and Repeals

This suggests that states played a pivotal role in constructing family cap policy and in influencing federal reform efforts that culminated in 1996 under a Republican congress. In fact, the family cap became a symbolic centerpiece of national welfare reform debates, as illegitimacy was a primary theme of Speaker of the House Newt Gingrich's Contract with America. Figure 1 demonstrates another important pattern in the evolution of family cap policies. Beginning in 1998, Wisconsin became the first state to repeal caps followed by 6 other states and with Minnesota being the last to repeal in 2013. The Californian state legislature is currently embroiled in legislative efforts to repeal the cap there.

The Centrality of Race and Social Control in U.S. Welfare Policy

Racial effects have become a standard explanation for transformations in poverty governance in the United States. One body of historically grounded work suggests that race has always shaped governmental approaches to managing poverty, labor, and criminal justice (King and Smith 2005; Lieberman 2001; 2007; Wacquant 2001; 2009; 2010). Other theories focus explicitly on race and ethnic relations, highlighting the role of

racial threat, racial resentment, and racism on stringent welfare choices (Fellowes and Rowe 2004; Fox 2004; Gilens 1999; Soss, Fording and Schram 2011).

Scholarship on the role of race in the development of the early welfare state points to several explanations, including the role of politics and institutions in perpetuating racist, exclusionary social welfare policies. Building on research exploring the negative social legacy of slavery, Lieberman (2001; 2007) highlights how poverty governance in the 1930s hinged on overt forms of discrimination through outright exclusions and the economic exploitation of African Americans in the South. Katznelson's analysis (2005) of the New Deal demonstrates that the southern delegation of the Democratic Party molded New Deal legislation in such a way as to exclude most African-Americans from the benefits of laws governing the formation of unions, labor regulations, Social Security, and Veteran's benefits (Katznelson 2005).

More currently, Schram and his colleagues highlight the importance of racial bias in shaping local policies, drawing from a larger research tradition that seeks to elucidate the ways in which the targets of policy are publicly defined as being either deserving or undeserving of aid (Stone 2002; Schneider and Ingram 2005; Schram 1995). This line of inquiry suggests that after the 1960s, racial political cleavages helped pave the way for neoliberal reforms that devolved welfare control back to the states through a new policy framework of paternalism. This welfare regime employs a directive and supervisory approach to managing the poor (Gilens 1996; Hancock 2004; 2003; Soss, Fording, and Schram 2011; Wacquant 2001; 2009; 2010).

At the federal level, Soss et al. (2011) document how a growing movement of conservative elites used the pathologies of the black, urban underclass as a powerful set

of wedge issues to appeal to white voters. These political developments helped create the necessary conditions to enact a new paradigm of disciplinary poverty governance that eventually devolved control of welfare to the states. At the state level, they document the racially disparate impacts of welfare reform policies and argue that states with stronger “get tough” measures such as sanctions and family cap policies are disproportionately those states with larger African American populations.

Furthermore, situating their analyses within elite rhetoric and public opinion, Gilens (2001), Hancock (2004), and Simmons, Dobbin, and Garrett (2007) demonstrate that the welfare reforms passed and implemented in the nineties were promoted through discourses that portrayed African American males as violent and undisciplined and through characterizations that constructed a public image of welfare based on stereotypes of immoral, Black welfare queens who were neglectful of their children and sexually promiscuous. Thus, relative to white Americans, Black minorities remain strongly associated with low work effort, poor motivation, socially disruptive behavior, and preferences for welfare reliance (Gilens 1996).

Applying these findings to state policy development Soss et al (2001; 2011) propose a Racial Classification Model (RCM) of social policy choice to specify the sufficient conditions that are sufficient to produce racial disparities in policy actions among states (Soss et al. 2001). Framed as a cognitive model of decision-making, the RCM is premised on the assumption that actors utilize social classifications and the consequences of group reputations in designing and implementing public policy (Schneider and Ingram 1993).

The main point of these studies is that the public perception of welfare as a “Black” program contributes to the ease with which policy makers adopt punitive policy measures. In the welfare to work context, policy choices are likely to reflect racial group reputations for work effort, personal responsibility, and productivity. Given that Black minorities, in particular, remain strongly associated with low work effort and motivation, laziness and a desire to obtain public assistance, the RCM predicts that the type of welfare recipient perceived as prevailing in a local jurisdiction will depend on the racial composition of states. In states where the size of the minority population is small, racial classifications will be less salient for officials.

The general importance of the size of Black populations on these dimensions of welfare reform policy is clear, but the presence of Latino populations on the adoption of punitive welfare regulations is more mixed (Avery and Peffley 2005; Fellowes and Rowe 2004; Soss et al. 2001). Some models find a significant and positive relationship between Latino prevalence on TANF caseloads and stricter reforms (Avery and Peffley 2005; Soss et al. 2001) while others find a negligible association (Fellowes and Rowe 2004; Soss et al. 2001) depending on the key variable of interest. Given that Latino subgroups occupy different social positions in the U.S, it is unsurprising that the literature does not find overwhelming evidence for the effects of the prevalence and dispersion of the Latino population on devolutionary policies at the state level.

Social control theory asserts that get tough policies such as family caps represent the state’s attempt control labor markets and certain segments of the population. From an economic perspective, Piven and Cloward (1993) suggest that welfare programs are mechanisms for the regulation of local labor markets, and their function is enhanced

when local control allows for the regulation of work enforcement to meet the needs of local labor market conditions. The need for regulation should accelerate when employers confront scarcity when unemployment is low or in states where employers confront tighter labor supplies indicated by a lower unemployment rate.

Wacquant (2009) undertakes a broad interpretive reading of American social policy and argues that the penalization of poverty represents a fourth period in the reproduction of ethno-racial hierarchies in the United States.⁵ Citing the sharp increase in the incarceration rates among Blacks, Wacquant suggests that stringent welfare reform policies represent a new regime of social control intended to confine and subjugate African Americans (Wacquant 2009, 2010). Criminality and “get tough” welfare reform serve as tools to manage disorder among African Americans in an era of deregulated markets. For Wacquant (2001), neoliberal paternalism is a coherent regime in which the “ghetto and prison meet and mesh” as an integrated system designed to discipline and contain “dishonored, lower class African Americans” (121). Thus states that place a greater emphasis on behavioral control through the criminal justice system are expected to enact punitive welfare policies such as the family cap.

The Politicization of Motherhood and Reproduction

Morality Politics and the Development of Paternalist Reforms

The evolution of federal assistance programs over time demonstrates how welfare policies also encapsulate changes in the normative expectations of women as mothers. For example, historical feminist research on the welfare state highlights how gender inequalities and traditional gender roles were reinforced through the continued

⁵ According to Wacquant, the three prior “peculiar institutions” that designate the social control of African Americans include slavery (1915-68), Jim Crow (1865-1915), and the racially defined ghetto (1915-68).

development of a two-tiered social welfare system beginning in the early 1900s. Mettler (1998) documents that white men were more likely than women and racial minorities to qualify for federal entitlements geared towards workers. For example, federal programs such as Workers' Compensation were designed for wage earners and offered relatively high benefits and minimal requirements and regulations. In contrast, racial minorities and women were more likely to receive public assistance, which was more stigmatized, more tightly regulated, and administered through state and local governments. Mettler concludes that public assistance for poor mothers was designed to buttress the family wage system and reinforce the expectation that mothers' primary responsibility was to care for their children. These institutional patterns are crucial because they laid the groundwork for local activists and bureaucrats to shape state and urban policies related to women and children.

Linda Gordon (1994) and Gwendolyn Mink (1995, 1998) trace the origins of racial and gender inequality in the American welfare state to the attitudes of middle class white reformers who helped pass and implement Family Preservation policies such as Mothers' Pensions. They argue that one of the primary purposes of Mothers' Pensions was to facilitate the cultural assimilation of Southern and Eastern European immigrants. Rejecting scientific ideologies that defined cultural differences as inherited and immutable, reformers "sought to create one motherhood from diversely situated women" (Mink 1995, 10). In practice, states extended pensions to immigrants with the condition that these groups conform to white norms regarding child rearing and "American" family standards. This practice ensured that children would be nurtured to worthy citizenship.⁶

⁶ The experience of Latinas was more mixed and often contingent on the region, local labor markets, and the citizenship status of the local Latino population. Importantly, Fox (2012) finds that the extent of

Black mothers, on the other hand, were simply excluded from pensions and the early implementation of AFDC because they were categorized as workers who were permanently outside of the realm of white domesticity (Fox 2012). The civil rights movement finally opened the welfare system to Black citizens, but this “racialized” legacy of welfare policy arguably broadened and became more explicit in the seventies and eighties (Gilens 2003). Until the 1960s, poverty was overwhelmingly portrayed as a “white problem,” but as black women joined the roles, AFDC became increasingly associated with Black mothers who were already stereotyped as lazy, irresponsible, and overly fertile (Gilens 2003). Welfare programs that were once reserved for white women soon became stigmatized as dependency and “proof of Black people’s lack of work ethic and social depravity” (Roberts 1997, 207).

There is substantial evidence that family cap policies are aimed primarily at presumably immoral women of color who are responsible for a crisis of illegitimacy. This welfare dependency thesis suggests that AFDC was too permissive and actually encouraged socially destructive behaviors such as joblessness, out of wedlock childbearing, and crime (Kaufman 1997; Lieberman and Shaw 2000; Walker 1999). With the adoption of TANF, the original intent of social welfare policy shifted from policy designs aimed at fighting poverty to a new welfare regime that attributes welfare dependence to antisocial behavior and a “culture of poverty.” Welfare reform rhetoric describes childbearing by the poor as fueling a cycle of poverty by producing children who will inevitably rely on the government for assistance. For example, contemporary social conservatives such as Charles Murray argue that “illegitimacy among the poor is

reformer paternalism was far less in regions in the west and southwest where growers relied more heavily on migrant workers who were non-citizens.

the single most important social problem of our time” and higher fertility rates among groups with “lower than average intelligence” perpetuate dependency and other social ills (Murray 1993, 10). In sum, the rhetoric of irresponsible reproduction claims that welfare recipients lacking a sense of responsibility and a stable family structure require punitive restrictions to curtail their propensity to have numerous children for the purpose of getting welfare benefits.

The Politics of Reproductive Health and Abortion

Amidst these racist, classicist, and normative expectations of what constitutes “good mothering” among the undeserving poor, there are other developments that increasingly politicize mothering and reproduction. In particular, political conflicts about social welfare policies increasingly center on the regulation of women’s bodies. Social policies are not simply aimed at behavioral modification strategies that decrease welfare dependency. Social policies increasingly use the tools of reproductive health regulation to combat perceived social pathologies among the poor. This implies a growing medicalization of poverty.

Related to policies aimed at sexual regulation, the 1970s marked the beginning of a women’s social health movement in which some women advocated for more control over their bodies and healthcare, including fighting for the right to have legal abortions and more access to contraceptives (Baird, Davis, and Christensen 2009). Related to contraceptive use, national mobilization surrounding publicly funded family planning efforts led to the successful adoption of laws enacted in 1970 under the Title X Family Planning Act and through the expansion of Medicaid programs in 1972. Through grant applications, title X provides access to contraception, counseling services, preventative

care and health screening, with particular emphasis on low-income populations (Gold et al. 2009). These services are offered through a network of community health care centers, Planned Parenthood Affiliates, and state and local health departments. Medicaid requires states to provide contraceptives, along with the appropriate obstetric examinations and testing, for qualified women of childbearing age (Gold et al. 2009; Kearney and Levine 2009).

Importantly, by the 1990s, as the women's health movement grew and achieved success, many activists began to work within medical institutions to achieve regulatory gains (Baird, Davis, and Christensen 2009). Institutional protest became a new phenomenon as social movement participants began to occupy formal statuses within government and pursue social movement goals through bureaucratic channels (Katzenstein 1999). Banaszak (2005) demonstrates how activist and organizations now straddle the traditionally drawn boundaries between state and social movements, and she has labeled this overlooked area "state movement intersection." For example, in a study of the passage of the family and medical leave policies of the early nineties, Bernstein (2001) finds that in order for activists to be successful, they had to express their demands in institutionally acceptable terms and be more likely to comprise than outsiders. Regulatory politics became a crucial space for reproductive health advocates imposing incremental changes at the state level. As a result, liberal women's health activists have increasingly worked within the state and now have a wide array of non-protest tactics available to them. In the case of family planning and abortion politics, institutions provide access points for insiders and success is garnered through achieving regulatory reforms within bureaucratic agencies. For example, through the work of progressive

bureaucrats, a number of states obtained Medicaid waivers in the early nineties, allowing them to expand coverage of family planning services in Medicaid, and some states have diverted state funds, funds from the Social Services Block GRANT, funds from the Maternal and Child Health Services Block Grant and TANF to augment funding from Medicaid and Title X (Gold et al. 2009). Further, after suffering defeats in abortion access in the late seventies, women's health movements sustained some level of success in diverting state funds to publicly fund abortions in 17 states.⁷ In sum, there is substantial evidence that women's health activists have altered medical conceptions of women, broadened reproductive rights, expanded funding and services in many areas, and have changed medical practices (Brown et al. 2004; Morgen 2002). Yet, the increasing lens of public reproductive health has modified how social actors frame and respond to the needs of poor women. Indeed, the increasing reliance on paternal reproductive health strategies imposes a clinical gaze on poor women, and policy solutions are increasingly diverted to individual-level behavioral modification interventions, which are discussed in chapters 3 and 4.

Progressive efforts to widen contraceptive access and publicly fund abortions have, of course, stimulated a strong anti-abortion and family values movement that has worked at multiple levels of government to reduce access to abortions and promote alternative contraceptive policies such as "abstinence only." Related to abortion, *Roe vs. Wade* was a pivotal victory for abortion rights activists, but it also presented a mobilization opportunity for abortion opponents. While the abortion movement had been

⁷ As of 2015, 32 states and the District of Columbia follow the federal standard and provide abortions in cases of life endangerment, rape, and incest. 17 states use state funds to provide all or most medically necessary abortions. Four of these states provide such funds voluntarily.

highly active on the national level before *Roe vs. Wade*, the anti-abortion movement took the strategic lead in the 1970's through mobilizing and influencing policy at multiple levels of American government. For instance, at the national level, anti-abortionists made Congress a new venue in seeking to overrule the courts, and they used state and local channels to fight for restrictions on funding abortions and fetal research after abortion was legalized. Immediately following the *Roe vs. Wade* decision, the Medicaid program federally mandated that states cover the cost of an abortion for eligible, low-income women. However, with the influence of anti-abortion lobbying, Congress passed the Hyde Amendment in 1976 banning Medicaid funding of abortions, and in 1977 the Supreme Court ruled that states could ban funding of abortions. These national developments were critical because they shifted control of abortion policy making to the states. For example, and similar to the institutional protests of reproductive health activists, the pro-choice movement has successfully worked at the state level since the early 1990's to place restrictions on abortions, and there has been an unprecedented wave of anti-abortion policies in the last few years (Kreitzer 2015). They are also relevant in understanding the development of family caps because states with more non-restrictive abortion policies became targets for social conservatives to undermine liberal health policy efforts. In fact, states like New Jersey began experimenting with alternative fertility policy solutions that were meant to deter unwanted pregnancies in the first place. Family caps became the poster child for these efforts.

In sum, the politics of reproduction among the poor incorporates a long political struggle between progressive women's social movements mobilizing for reproductive health rights and conservative anti-abortion activists that mobilize for less access to

contraception and abortion among poor women. As social conservatives have lobbied for policies aimed at reducing out-of-wedlock births and less government dependency, progressive women's health movements have fought for equal access to promote reproductive health among poor women. In the case of family caps, social conservative groups envisioned these measures as an innovative preventative reproductive health strategy designed to regulate the fertility of women.

The Politics of Family Cap Repeals

The evidence that family caps produced a decreasing number of births and a rising number of abortions had a stirring impact on the political debates surrounding early reform effort both within states and at the federal level. In 1998, a study by Rutgers University found that caps were correlated with rising abortion rates. For instance, Chris Smith, a U.S. Representative from New Jersey told the *New York Times* in 1995, "If you take away funding for the poorest of our children and pay for abortions on demand through Medicaid, like New Jersey and New York and many other states do, it doesn't take a rocket scientist to conclude that you are either going to have poorer children or dead children" (Peterson 1995). Rising abortion rates not only presented proponents with a credibility problem, but they made it difficult to define family caps purely as anti-pregnancy or pro-conception programs.

Indeed, qualitative evidence suggests that these research findings ignited a split that divided conservatives into two camps: those for whom abortion was an acceptable response to an attempt to reduce out-of-wedlock births and those who found abortion to be a repugnant form of moral corruption. For instance, neoconservative and libertarian elements of the right who are typically weak on pro-life continue to dispute evidence that

caps increase abortion rates. For example, policy experts with affiliations at the American Enterprise Institute and the Welfare Reform Academy reject the correlation between abortion rates and family caps and argue that the measure successfully reduces welfare dependency by altering the choice architecture of individuals who have been conditioned to a life of dependency (Lewin 1995). To wage their claims, they commonly cited studies conducted by researchers from Baruch College, The University of Illinois at Chicago, the Alan Guttmacher Institute, and the National Bureau of Economic Research which found that family caps did not influence women's decisions about whether to have children

In contrast, when family caps became linked with rising abortion rates among the poor, some pro-life groups and the Catholic Church not only denounced the policy but began to lobby actively against the passage of this reform in other states. In a counterintuitive move, they formed coalitions with various women's groups and civil rights groups to fight to repeal the measure in several states (Albrecht-Popiel 1994; Bapat 2013). For example, in North Dakota, advocates of the repeal argued "The experience of the Catholic Church and pro-life organizations, as well as New Jersey's experience with the family cap, led us to believe, and still believe, that the provision encourages abortion" (Dodson 2001, testimony). In Illinois, the Catholic Church and the ACLU actively fought to repeal the measure, arguing that the government was willing to pay women to have abortions but not to support their children (Daly and Lewis 1995). And in 2016 Minnesota and California had two bills on the floor of each state's legislature to repeal the law. Pro-life advocates, women's reproductive health groups, and the Catholic Church all continue to lobby against the law on the grounds that it promotes abortions. For example, in testimony to the Minnesota Senate Health, Human Services, and Housing

Committee, the Minnesota Catholic Conference testified that "...the Family Cap creates an incentive for women to abort their babies in order to avert the impending economic hardship of raising a child without additional benefits" (Adkins 2013).

This suggests that the story of family cap policy reform is as much a story of the conflicts between and among conservatives as it is a conflict between liberals and conservatives. In this case, social conservatives may have rescinded their initial support for family caps after family cap evaluation research indicated that caps increase abortion rates. While enduring discourses about racialized illegitimacy have a strong effect on a given states' likelihood of adopting family caps, political actors may have learned from policy innovators and choose to pursue alternative *solutions* to uphold their original commitment to protect the sanctity of the hetero-normative family. For instance, several socially conservative think tanks now advocate that in order to combat poverty and dependence, it is vital to strengthen marriage by overhauling policies that reduce benefits when a couple's joint income increases (Heritage Foundation 2013).

Theoretical Expectations

These policy developments suggest that multiple factors are likely to lead to the adoption and repeal of family caps. As the previous discussion illuminates, a legacy of racial bias, political learning on both the left and right, the political environment, and the strength of conservative and progressive social movements are likely to impact the timing of state adoption or repeals of this disciplinary policy measure. Building on the previous discussion, this section offers formal theoretical expectations and hypotheses to quantitatively test these political developments. Given that the legacy of racial bias and

social control is well documented in the literature and in the first part of the chapter, I limit my discussion to social movement strength, political factors, and policy learning.

The Influence of Progressive and Conservative Social Movements

The qualitative discussion highlights that the politicization of motherhood and reproductive health suggests that the influence of social movements on state policy adoption is understudied. Adding to the literature, I posit that social movement strength matters to policy change because it has direct effects on lawmakers through lobbying and informational sharing (Berry 1999; Mahoney and Baumgartner 2008; Piven 2006). (Cress and Snow 2000; Skocpol et al. 1993; Soule and Olzak 2004) In the context of social policy, we should expect that a variety of different kinds of associations influence welfare policies at the state level because the landscape of social welfare politics and social service delivery has shifted dramatically since the 1960s. Professionally managed advocacy groups and institutions have grown exponentially in the United States (Skocpol 2003). At the national and state level, contemporary foundations and think tanks increasingly distribute grants to chosen groups, pet policy projects, and they often assemble experts to address public policy issues. These developments are important because current policy debates about social welfare and the “pathologies of poverty” are often grounded in struggles between these groups. More critically, the terms of these struggles are often played out through scientific debates that leverage policy intervention evidence to influence political debates among state bureaucrats and elected officials.

Additionally, and especially related to issues of welfare policy, advocacy surrounding social policy has moved away from centralized, national civic organizations to those that are decentralized and local (Skocpol 2003). In states and localities, a variety

of nonprofit institutions and state bureaucrats play leading public roles while at the same time delivering services to the public. “Human service providers, community foundations, and many other professionally run organizations focusing on creating goods for states and localities are where the action is for community elites, who vie to sit on the boards” (Skocpol 2003). Local and state nonprofits are important because they are now as much involved policy advocacy as national groups. This local shift suggests that, as welfare policy has devolved to the state level, these associations are more equipped to impact welfare politics under certain conditions.

Nonprofit organizations are increasingly intertwined with the government. As Berry (1999) argues, non-profits are key political actors because they cooperate closely with local government to co-produce local programs. In sum, social movement organizations should affect policy makers because they strategically use institutionalized tactics, such as litigation and lobbying, to influence policy outcomes. As the historical analysis makes clear, social conservatives were early proponents of family caps, but later reversed their support for these repeals as they learned that this punitive measure was encouraging abortion. *I expect that states with strong pro-life movements are more likely to adopt family caps in the early years of welfare reform compared to states with weak pro-life movements. Over time, I expect that states with strong pro-life movements are more likely to repeal family caps in response to research findings related to abortion.*

Conversely, progressive reproductive health movements adamantly opposed the passage of family caps because this measure infringed on poor women’s reproductive health rights. Similar to welfare rights activists, progressive liberal health reformers spent years working to increase poor women’s access to a variety of reproductive health

services. Family caps were an explicit attempt to regulate and stigmatize the reproductive behavior of poor women. Consequently, *I expect that states with strong reproductive health movements are less likely to adopt reforms compared to states with weak reproductive health movements.*

Political Ideology and the Influence of Political Parties

Another group of factors expected to influence family caps is based on the effects of political and institutional characteristics in states. According to the government ideology thesis, family cap policies are driven by ideological factors. In the U.S, family caps are often portrayed as a conservative policy innovation (Conlan 1998). For instance, Erickson, Wright, and McIver (1993) find that more liberal state governments spend more on welfare than less liberal governments, a finding that is replicated in a longitudinal analysis by Berry et al. (1998). The expectation of each of these theories is that as institutional pressure for welfare generosity dissipates (i.e. a state government becomes more conservative) the likelihood of the adoption of the family cap decreases. Stated more formally, *I expect that States with more liberal government ideologies will be less likely to adopt family cap measures compared to states with more conservative government ideologies. Conversely, I expect that states with more liberal government ideologies will be more likely to repeal family cap measures when state lawmakers are more liberal.*

There is also evidence that partisanship is likely to affect the timing of state adoption and repeals. As the qualitative analysis reveals, there is strong evidence that members of the Republican Party were more sympathetic to these policies than were members of the Democratic Party. There is also substantial evidence that Democrats

generally support more liberal social policies (Huber, Ragin, and Stephens 1993; Barrilleaux, Holbrook, and Langer 2002). *In short, I consider Republicans allies of family cap adoption and Democrats allies of repeals.*

Political Learning and Policy Diffusion

The historical analysis suggests that family cap policies have evolved, in part, because policy actors learned from experiments in other states and responded to the unintended consequences of family cap reforms. In the theoretical policy diffusion literature, there is consensus on three broad classes of diffusion mechanisms that impact state policy choices: learning, emulation, and competition (Braun and Gilardi 2006; Graham, Shipan, and Volden 2013; Shipan and Volden 2008; Simmons, Dobbin, and Garrett 2006, 2007). While there is evidence that policy makers learn about all of these dimensions, I focus on the effects of “learning” on family cap adoption and repeal. Learning not only encompasses gaining knowledge about innovative reforms, but states also learn from the successes and failures of early adopters (Gilardi 2010; Meseguer 2004; Volden 2006; Volden, Ting, and Carpenter 2008). Maggetti and Gilardi (2015) shows that there are different forms of success or failure that transmit across states. Success can be related to the goals that the policy is designed to achieve, the challenges of its implementation, and its political support. For instance, Volden (2006) demonstrates that U.S. states were more likely to adopt some health insurance programs when they learned about policy successes in another state. In his study, states were more likely to imitate health insurance programs targeted to needy children from other states that had managed to increase insurance rates while keeping costs low compared to those states where costs escalated. In the case of family caps, I argue that learning influenced the

timing of family cap policy choices. *In short, I expect that policy adoption is less likely over time because states learned that this controversial measure did not successfully increase marriage rates or decrease abortion rates*

Data and Methods

In order to test the impact of a perceived crisis of illegitimacy and race on the likelihood of the adoption of family caps, the quantitative analysis investigates the social, political, and economic factors that shape state policy choices from 1990 to 2010. The original data set includes panel indicators of state welfare reform policies across the U.S. states compiled by the Urban Institute and other sources. The data set also includes a number of time varying indicators, from various sources including U.S. census data, TANF caseload statistics from the Department of Health and Human Services, the Guttmacher Institute, and the National Center for Charitable Statistics. In specifying the models, I assume that state-level goals may be imposed from above by state officials or demanded from below by local policy actors. The unit of analysis is the state year. The sample for the analysis includes 49 U.S. states and excludes Nebraska because this state has a nonpartisan state legislature.

Several theoretical and methodological concerns motivate my choice of states as the appropriate level of analysis. Most obviously, the process I wish to explain occurred at the state level, so it is reasonable to assume that state-level politics and the organization activity of proponents and opponents were aligned with the state climate rather than national politics. While welfare reform was mandated at the national level, the reality is that states were the innovators of this monumental shift in the U.S. welfare state. Moreover, repeals occurred in the absence of any federal legislation. State-level analyses

are also especially useful for analyzing the expansions and retractions of regulation in U.S. welfare provisions. As I argued above, deregulation and decentralization require choosing state-level analyses because policies relating to poor women and children have historically been relegated to the states, and, in an era of neoliberal deregulation, important policy decisions have devolved to their control as well.

Key Dependent Variables

For the models that analyze the determinants of family cap adoption, the dependent variable in the analysis is dichotomous and is coded 1 for all states that adopted the family cap, 0 for non-adopters, and missing after the policy is adopted. The coding scheme is reversed for repeals. The adoption of family caps comes from several data sources, including the Urban Institute, the Center for Law and Social Policy (CLASP), state reports, and the National Conference on State Legislatures. Since the aim of this analysis is to understand the process and timing of policy adoption, I triangulated all of these sources to include the year that states adopted or repealed (as opposed to implemented) family caps. When two data sources conflicted, I consulted state reports and newspaper articles to validate the data. All of these decisions are documented and available upon request. Previous studies have relied on the Urban Institute to test the determinants of family caps. This is problematic because this data set captures implementation dates of policies. Analyzing implementation years is likely to underestimate the effects of political factors on family cap adoptions because implementation occurs **after** the politics of reform occur. From a methodological standpoint, my approach offers an important contribution because it corrects for this future-time error in previous studies.

Key Independent Variables

The analyses presented below were designed to test hypotheses about the factors that led to the state-level adoption of family caps and some repeals. All of the data for these time varying independent variables are measured yearly to correspond with the years in which states adopted or repealed the reform. When data were not available for every year, I used linear interpolation to estimate between-year values. The appendix lists the descriptive statistics and measurement strategies of these explanatory variables. The key variables of interest test the strength of social movements, state ideology, partisanship and political learning on a state's propensity to adopt and repeal reforms.

To test for the relative strength and success of progressive and conservative social movements, I use a number of original proxy variables for the analyses. The gold standard would be to collect data on the numbers and presence of state level nonprofits and advocacy organizations for progressive women's health movements and social conservatives to construct measures of organizational capacity (see e.g. Weldon 2006 2011). Unfortunately, collecting state-level data from 1992-2010 is nearly impossible. While the *Encyclopedia of Associations: Regional, State and Local Organizations* exists, the data is out of print in the early nineties, and the cost to purchase the data from 2005 onward is beyond the research budget of this project.

Instead (and as I showed earlier) progressive women's health movements have advocated for more equitable reproductive health policies for vulnerable populations by working within state bureaucracies to increase access to publicly funded family planning services, including abortion. The purpose of these tactics is two-fold. Advocates suggest that family planning policies allow women to gain greater control over their childbearing,

reduce teenage pregnancy, reduce the risk for the transmission of sexually transmitted disease, and reduce unwanted pregnancies. In short, they promote women's health. Second, these tactics promote change from within and create institutionalized pathways for future reforms.

To capture the presence of and success of these "institutional protests," I include an ordinal measure of the institutional success of female health activists. This original measure codes the degree to which states support publicly funded abortions from 1990-2010. The ordinal scale is coded: 1) the state only pays for abortion in life threatening circumstances; 2) the state pays for abortion in cases of threat to life, rape, and incest; 3) the state pays for abortion in cases of life, rape, incest, and other medical conditions; 4) the state pays for abortions under court order; 5) the state pays for abortions voluntarily. The data was coded from a variety of sources, including reports from the Guttmacher institute, state policy reports, and the Kaiser Institute. I expect a negative association between non-restrictive public funding of abortions and family caps.

To capture the effects of social conservative movements on the adoption and repeal of family caps, I include two measures to test my theoretical expectations. Advocacy interest groups appear on both sides of abortion, but the two advocacy groups that are mobilized, active, and fervently anti-abortion are Catholics and fundamentalist Evangelical Christians. Both share intense beliefs on the sanctity of life and even equate abortion with murder (Goggin 1993; Wilcox 1989). Meier and Mcfarlane (1993), Berkman and O'Connor (1993), and Cook et al. (1993) demonstrate that both groups are strongly associated with anti-abortion activities, including lobbying, making campaign contributions, and protesting. Following the work Cohen and Barrilleaux (1993), Medoff,

Dennis, and Stephens (2011), and Roh and Haider-Markel (2003), I use as a measure of anti-abortion group strength the percentage of the population that is Catholic and the percentage of the population that belongs to an Evangelical Christian denomination in each state. The percentages of state populations that are members of these churches was collected for each state in 1990, 2000, and 2010 from the Association of Religion Data Archives from the Glenmary Institute. I linearly interpolated the values for the missing years.

In order to capture the effects of institutional pressures on the adoption of family caps and repeals, I use an indicator of state government ideology developed by Berry and colleagues (1998). Higher scores indicate more liberal scores of government ideology, so the expected direction of this variable is negative. To capture the effects of the presence of elite allies on family caps and adoptions I use a measurement of the partisan balance of government developed by Carl Klarner (1993). If a party has more than 50 percent of the seats in a chamber for a two-year legislative cycle, they are coded as 1 for Republican control and 0 otherwise. The reverse is true for Democrats. To capture political learning and diffusion, I account for these duration effects in the form of years since the first state adopted.

To capture the racial effects on family cap policies, I include a measure of the percentage of Blacks and Latinos in each state by year. This measure is valid given the robust and positive effects of the prevalence and dispersion of Blacks on stringent welfare policies (Fellowes and Rowe 2004; Soss et al. 2001). Additionally, where the African American welfare population has been larger, states have been more prone to submit waiver requests (Zylan and Soule 2000), voters have been less willing to pay for

welfare programs (Plotnick and Winters 1985), and states have provided lower AFDC benefits (Howard 1999; Orr 1976; Wright 1977). For each racial composition measure, I expect a positive association with the adoption of family caps. That is, states should be more likely to pass family cap policies when the prevalence of Blacks and Latinos residents increases. Moreover, I expect that the timing of repeals should be negatively correlated with these racial measures.

To test for the effects of social control on family cap adoption, I include two variables in the model. The first variable tests the hypothesis that family caps reflect the state's attempt to control local labor markets. To capture these effects, I include the state unemployment rate by year. The expected direction of this indicator is negative.

Following prior research, I control for the hypothesis that get tough welfare policies are a mechanism of social control by including expenditures for incarceration rates across states. I expect that states with larger expenditures on incarcerations are more likely to adopt family cap policies compared to states with lower expenditures.

Finally, I include an indicator of the percentage of unmarried births in each state by year. While this variable does not offer an explicit measure of the normative beliefs of policy makers, it offers a proximal test of whether the reproductive behavior of citizens may influence state policymaker's decisions about redistributive policies (Fellowes and Rowe 2004; Mead 1997). Presumably, state policymakers adopt family caps in response to higher unmarried birth rates. The logic here is that as "immoral" behavior increases, policymakers adopt family caps as a deterrent for using welfare as a viable source of funds for fueling the growth of an urban underclass (Murray 1984). Indeed, the extent of illegitimacy among welfare recipients is found to have influenced welfare generosity in

the past (Plotnick and Winters, 1985). I expect a positive association between the unmarried birth rate and state adoption of family caps. For repeals, I expect a negative association.

Analytic Strategy

Event history analysis (EHA) has become the standard approach to modeling policy diffusion across the American states. EHA allows scholars to control for internal and external determinants of policy adoptions simultaneously, and it emphasizes the unique determinants of a specific policy instead of emphasizing a general or broader discussion of learning (Boehmke 2009; Grossback, Nicholson-Crotty, and Peterson 2004; Kreitzer 2015). Event history techniques explore the process of state policy adoption, and this technique is relevant here because this research is interested in the relative likelihood and timing of policy adoption, diffusion, and repeals. A key advantage of this approach is that a state is no longer in the data set once it has adopted the policy.

Most studies of policy adoption in the U.S. states only consider the adoption of policies. However, the policy analyzed here has three potential outcomes: no adoption, adoption, and repeal. Repeals are also dependent on adoptions, which complicates the design. To account for these multiple and contingent outcomes, I use two discrete event history analyses to model both risk sets. In model 1, I use a standard EHA approach, in which family caps are coded as 1 for the time period in which the policy is adopted, 0 for the time period when the state is in the “risk set” of states that have not yet adopted, and “missing” for the years after the state policy has been enacted. The period of analysis for Model 1 is 1990-2005. As table 1 indicates, the risk of states adopting family caps is extremely low after 1998, and by 2004 the risk is 0.

In Model 2, I limit the analysis to states that have adopted the reform and exclude non-adopters. This is important because states are only at risk for repeal once they have adopted the policy. Non-adopters should be excluded from the model because they are not “at risk” for repealing. Family cap repeals are coded 1 for the year in which the policy is adopted, 0 for the time period when they are at risk (the years the policy is enacted), and missing after they repeal. The period of analysis for Model 2 is 1998 to 2010. This covers the time frame when the first state, Wisconsin, repealed in 1998 and ends in 2010. Minnesota repealed the policy in 2013, and California is currently repealing the policy, but the study excludes these cases due to data limitations.

It is important to note that while continuous survival analysis does allow for multiple outcomes in one model, I have chosen to use discrete event history analysis for a number of reasons. First, family cap adoptions and repeals only occur at regular, discrete points in time (years). Second, all of the state-level covariates are measured in yearly increments. Third, there are numerous ties in the data set because many states ratified family cap policies in the same years. For example, six states adopted family caps in 1995. For these reasons, discrete event history analysis is appropriate due to the data structure. Continuous survival analysis is inappropriate because it requires that failures be reported in shorter time frames such as by the day of adoption. As is common in the application of EHA in policy studies, this study uses the year of adoption because poor data quality prevented me from distilling the actual passage date. Indeed, it took considerable time to validate that the years included in this analysis were the adoption year and not the year of implementation.

Results

I estimated separate models for the adoption of family caps between 1992 and 2004 and for the repeal of family caps between 1998 and 2010. Before I discuss the multivariate results, I discuss the hazard rates for adoptions and repeals of family caps. Table 2 shows the hazard probabilities and cumulative proportions of states adopting family caps for 12 years. The first three columns offer a narrative history of policy innovation from New Jersey adopting in 1992 to Minnesota adopting in 2003. Table 3 shows the hazard probabilities and cumulative proportions of states repealing caps for 12 years or from 1998 to 2010.

Whereas basic descriptive statistics for a risk set with censored time events only yield partial information about states that did not adopt family caps, the hazard rate allows us to examine policy diffusion sequentially among those states *eligible* to adopt new legislation at each discrete point in time. The hazard function is the conditional probability that a state will adopt or repeal in a calendar year given that the state has not previously adopted or repealed the measure. The magnitude of the hazard at each discrete interval indicates the risk of policy adoption in values ranging between one and zero, where higher values for the hazard rate led to a greater risk of adoption and diffusion.

Table 2: Hazard Rates and Cumulative Proportion of States Adopting Family Cap Laws, 1991-2005

Year	States Adopting Family Caps	Number Adopting in Year t	Cumulative Number of Adoptions	Cumulative Proportion of Adoptions = A_t^a	Risk Set	Hazard Rate = h_t^b
1991		0	0	0.00	49	0.00
1992	NJ	1	1	0.02	49	0.02
1993		0	1	0.02	48	0.00
1994	AR GA	2	3	0.06	48	0.04
1995	AZ IL IN MA MS VA CT FL MD NC SC	6	9	0.18	46	0.13
1996	WI CA DE ID OK TN	6	15	0.31	40	0.15
1997	WY	6	21	0.43	34	0.18
1998		0	21	0.43	28	0.00
1999	ND	1	22	0.45	28	0.04
2000		0	22	0.45	27	0.00
2001		0	22	0.45	27	0.00
2002		0	22	0.45	27	0.00
2003	MN	1	23	0.47	27	0.04
2004		0	23	0.47	26	0.00
2005		0	23	0.47	26	0.00

Source: The Welfare Rules Database, CLASP, and State Policy Reports

Notes: NE Adopted in 1996 but is excluded from the multivariate analysis

MN is excluded from the multivariate analysis

a. A_t = Cumulative number of adoptions in year t divided by 49

b. H_t = number adopting in year t divided by the number of states in the risk set.

There are several noteworthy things to mention here. First, as Table 2 clearly shows, the hazard rate for state adoptions significantly declines by 1998 and reaches 0 in 2004. In fact, the hazard rate remains 0 until 2010 (results not shown here). This validates my decision to consider appeals from 1991 to 2004. Put simply, these descriptive statistics suggest that the era of family cap adoptions is over because the hazard rate has remained 0 from 2 until 2010. Second, Table 3 shows that given the smaller risk set for

repeals, the hazard rate for repeals is consistently small. This has important methodological implications as the descriptive probabilities foreshadow a small n problem for a multivariate analysis of repeals.

Table 3: Hazard Rates and Cumulative Proportion of States Repealing Family Cap Laws, 1997-2005

Year	States Repealing Family Caps	Number Repealing in Year t	Cumulative Number of Repeals	Cumulative Proportion of Adoptions = A_t ^a	Risk Set	Hazard Rate= h_t ^b
1997		0	0	0.00	23	0.00
1998	WI	1	1	0.04	23	0.04
1999		0	1	0.04	22	0.00
2000		0	1	0.04	22	0.00
2001		0	1	0.04	22	0.00
2002	MD	1	2	0.09	22	0.05
2003		0	2	0.09	21	0.00
2004		0	2	0.09	21	0.00
2005		0	2	0.09	21	0.00
2006		0	2	0.09	21	0.00
2007	NE IL	2	4	0.17	21	0.10
2008		0	4	0.17	19	0.00
2009	OK WY	2	6	0.26	19	0.11
2010		0	6	0.26	17	0.00
2011		0	6	0.26	17	0.00
2012		0	6	0.26	17	0.00
2013	MN	1	7	0.30	17	0.06

Source: The Welfare Rules Database, CLASP, and State Policy Reports

Notes: Minnesota repealed in 2003

Nebraska is excluded from analysis

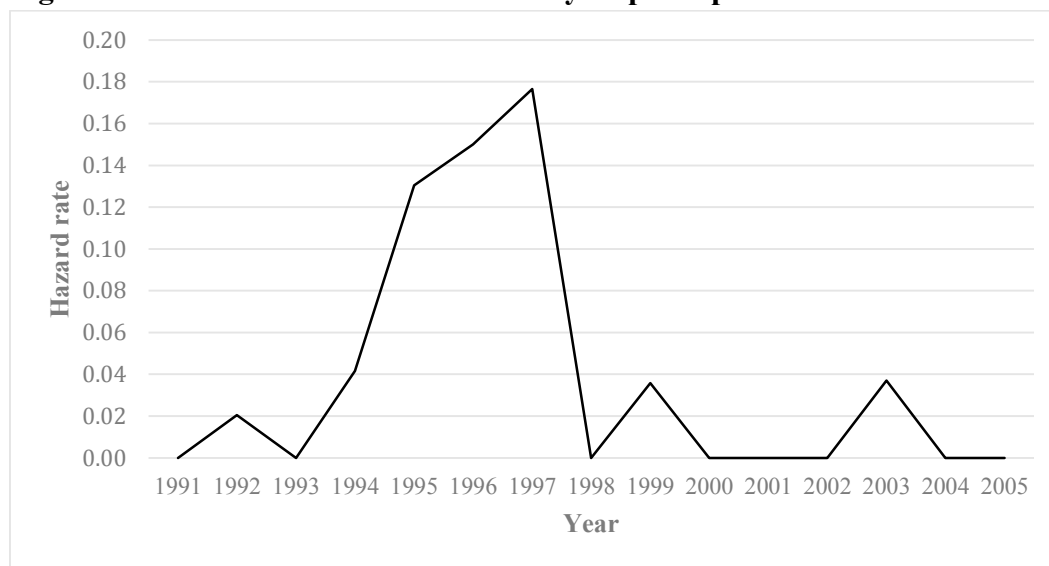
a. A_t = Cumulative number of adoptions in year t divided by 49

b. H_t = number adopting in year t divided by the number of states in the risk set

To illustrate the explanatory power of the hazard rate for studying state adoptions and repeals, Figures 2 and 3 graph the discrete hazard estimates over time. For example, Figure 2 shows the hazard probabilities as a longitudinal series of cross-sectional

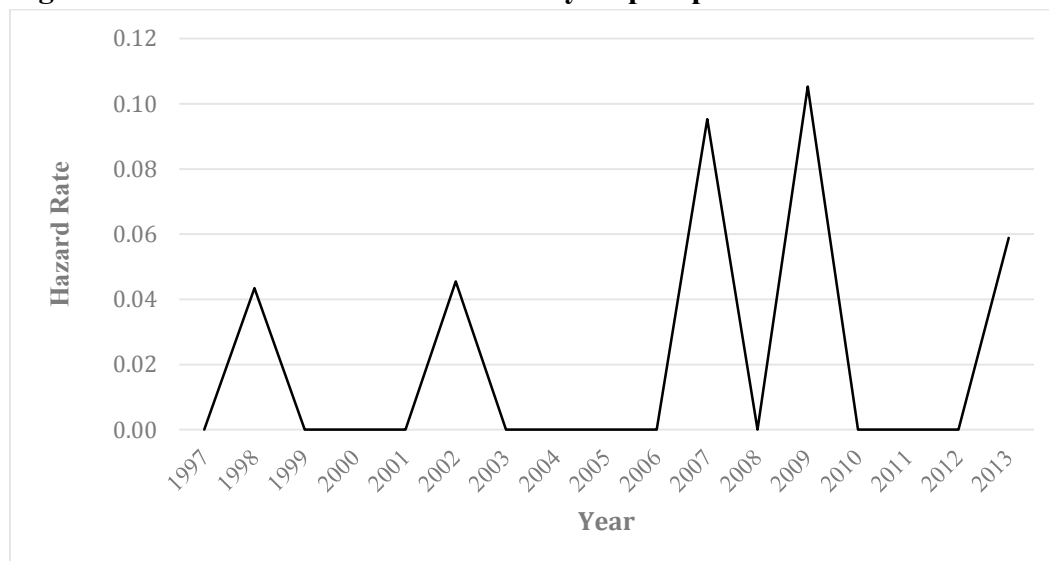
observations connected by lines. Both figures show that adoptions and repeals of family cap policies are non-monotonic functions with multiple peaks and valleys. Figure 2 shows the risk of policy adoptions sharply increased in the early 1990s, prior to welfare reform, and reached its peak in 1996 and 1997 as PROWRA was passed and

Figure 2: Hazard Probabilities for Family Cap Adoptions



implemented. Conversely, the hazard probabilities for repeals display multiple peaks and valleys with an increasing risk in 2013. This suggests that the risk for repeal is still present and that future states are somewhat likely to repeal the policy.

Figure 3: Hazard Probabilities for Family Cap Repeals



Policy Adoption

Table 4 presents the discrete pooled time event history analysis for policy adoption with variables related to the political factors, social movement strength, and many others. There were 23 “failures” in the model. That is, only 23 states adopted the controversial policy during this time period. Policy adoption in general is a rare event, but the event history analysis shows that many of the independent variables included in my model are significant and many have a significant substantive effect on policy adoptions.

The model supports multiple theoretical explanations that contribute to the timing of policy adoptions. In fact, the strength of my approach is that I am modeling multiple determinants across time using a model that more accurately takes into account multiple processes. In general, the model provides support for the importance of political context, social movement strength, and racial bias on punitive policy reforms.

Table 4: PEHA Estimates of Diffusion Family Cap Policies, 1991-2004

Political Context	Adoption
Liberal Ideology	-0.033** (0.015)
Republican Control	0.086 (0.690)
Years Since First State Adopted	-0.206** (0.093)
Progressive Social Movements	
Nonrestrictive State Funding for Abortions	0.481*** (0.202)
Conservative Social movements	
Catholic Adherence Rate	0.014 (0.026)
Evangelical Adherence Rate	4.058* (3.120)
Percent Unmarried	0.026 (0.064)
Racial Bias and Social Control	
Percent Black	0.072** (0.036)
	0.002** (0.0001)
Percent Latino	
State Corrections Spending	0.164 (0.142)
Unemployment	-0.524** (0.240)
Constant	-3.390 (1.980)
N	481
χ^2	32.07
AIC	176.6671
BIC	226.7775

Note. PEHA = pooled event history analysis. AIC = Akaike Information Criterion;

BIC = Bayesian Information Criterion

Single-tailed tests, * $p < .10$. ** $p < .05$.

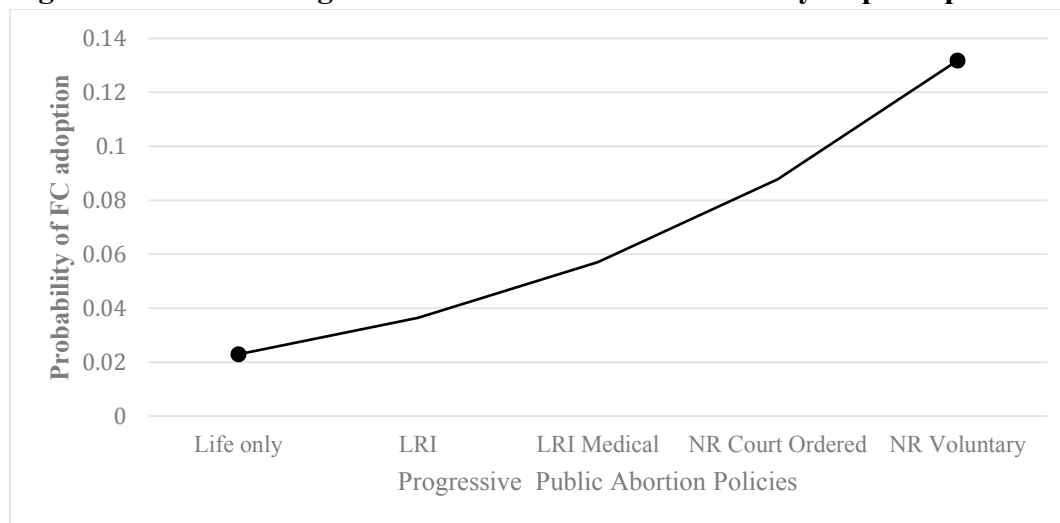
*** $p < .01$.

Standard errors in parentheses

Beginning with social movement indicators, the model indicates that states were *more likely* to adopt caps when progressive abortion policies were present in a given state. Indeed, and as Figure 4 elucidates, the effect sizes for this original measure are

substantial. The likelihood of adoption increases by 10% when states move from highly restrictive policies to non-restrictive public funding of abortion. These results are counterintuitive, implying that progressive social movements support punitive sexual regulation. One possible explanation for this unexpected finding is that the timing of family caps represented the effects of counter-mobilization strategies on the right. It may be that caps presented an opportunity for social conservative movements concerned with a decay in family values, increases in out-of-wed lock births, and liberal reproductive health policies to adopt a measure that would counteract these liberal initiatives.

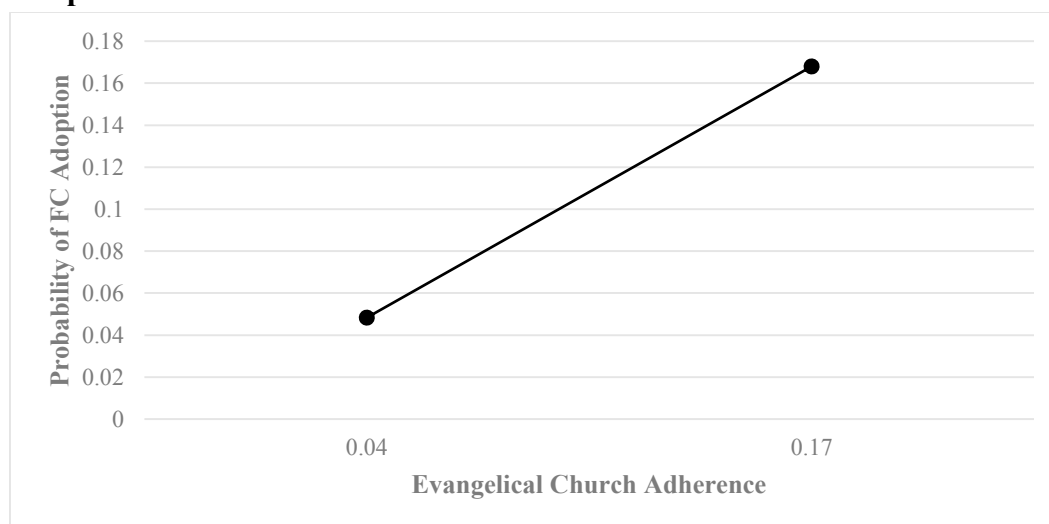
Figure 4: Effect of Progressive Abortion Policies on Family Cap Adoptions



The model also shows that the effects of conservative social movements are not homogenous. As the evangelical adherence rate increases, states are significantly more likely to adopt family caps while the effects for Catholic Church adherence and the unmarried birth rate are insignificant. The effect size for evangelical church adherence rates is quite substantial. As Figure 5 illustrates, states are 14.03% more likely to adopt family caps as the evangelical church rate increases from its minimum to its maximum. The lack of significance for Catholic adherence rates and the unmarried birth rate are

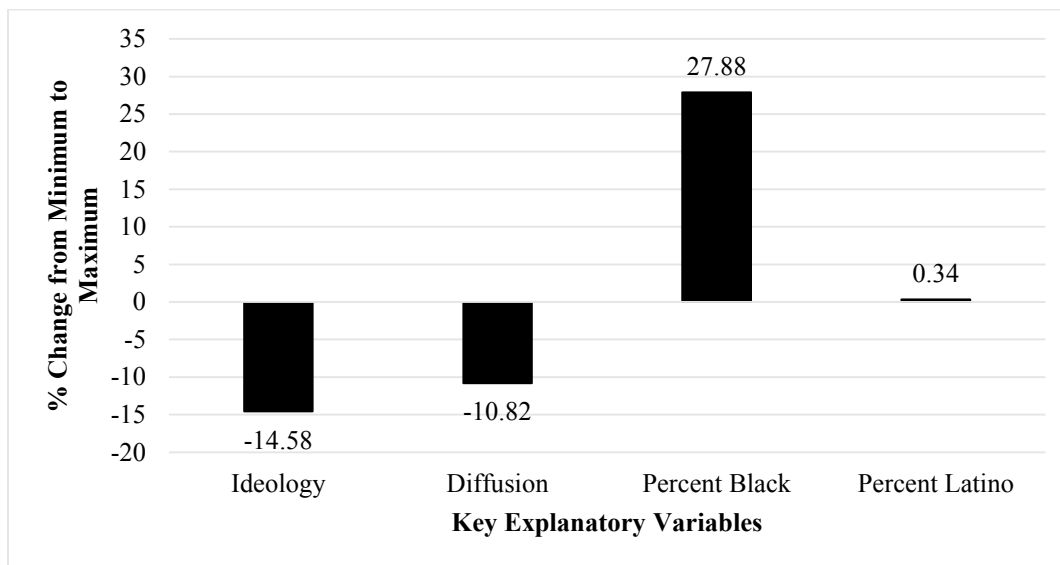
noteworthy. In the case of Catholic conservatism, this non-finding triangulates with the qualitative narrative analysis presented earlier. Recall that, early on, the evidence that family caps may promote more abortions ignited a split among conservative reformers. Indeed, the Council on Catholic Bishops became one of the most vociferous opponents of caps as the evidence of this policy “failure” ensued.

Figure 5: Effect of Pro-Life and Family Values Social Movements on Family Cap Adoptions



Turning to the state’s political context, I find that states that are more liberal are significantly less likely to adopt family cap reforms compared to states that are more conservative. As figure 6 shows, when I hold the other predictors at their mean, I find that liberal states are 14.58% less likely to adopt the policy.

Figure 6: Comparison of the Marginal Effects on State Policy Adoptions with Key Variables



Interestingly, I do not find evidence that partisanship affects the timing of adoptions in the study period. The correlation is positive and in the expected direction, but this non-finding may be due to the fact that bureaucratic activists played a primary role in designing this punitive policy experiment. Recall that many adoptions occurred under federal waivers and that state policy makers typically design new innovations in policy development. This makes sense in an era of devolution whereby the control of policy making is increasingly delegated to bureaucrats and contractors.

I also find strong support for diffusion effects. As the number of years since the first policy adoption increase, the model shows that states become significantly less likely to adopt family caps in subsequent years. The substantive effects of diffusion and policy learning are moderate. As shown in Figure 6, when I hold other predictors at their mean and the duration of years moves from its minimum to its maximum, states are 10.82% less likely to enact family caps. The implication of these results is two-fold. First, it suggests that as states learned that family caps did not affect pregnancy rates and may

have increased public abortions, there was a rapid decline in states' likelihood of enabling this "failed" policy. Second, family caps may have represented a highly symbolic "get tough" stance in the era of welfare reform. Once these highly visible public debates subsided, states became less likely to adopt this measure as they learned more about its failure as a behavior modification strategy and as the policy became stigmatized as a solution that possibly promoted public support for abortions. As policy debates increasingly centered on the evidence that family caps contradicted the original intentions of this behavioral modification strategy, conservative actors moved to other policy solutions to decrease illegitimacy and promote two-parent families.

The impact of race on punitive policy reforms is undeniable. Figure 6 shows that states are 27.88 percent more likely to adopt family caps when the variable changes from its minimum to its maximum. My results corroborate Soss and colleagues' assertions that the enduring poverty among African Americans is increasingly attributed to the pathological structure of the Black family (Hancock 2004). The focus on welfare dependency represents a move away from the "war on poverty" initiated in the 1960s to the "war on welfare" that began in the 1990s. In this way, the concept of dependency has been reframed from a structural issue related to income inequality to a behavioral modification regime with single, poor, Black women occupying center stage.

The effects of Latino racial stereotypes have also been inconsistent in the literature. This is likely related to cross sectional designs that measure the impact of a time-varying covariate in a fixed year. Using PEHA, I find that as the percent of the Latino population increases, states are indeed more likely to adopt caps. However, and as Figure 4 demonstrates, the effect size is negligible. This finding can be interpreted in two

ways. First, this marginal finding may be an artifact of the diversity among Latinos. More specifically, there is evidence that the sociopolitical relations that constitute “Latino” groups have created very different forms of marginalization depending on immigration status, national origin, region, city or state political economy, and the broader context of political incorporation (DeGenova and Ramos-Zayas 2003, 2004; Kim 2003). For these reasons, the percentage of Latinos may just be too blunt to characterize the heterogeneity of Latino marginality. Second, racial effects may be more pervasive with respect to Blacks. Unlike other minority groups, Blacks remain strongly associated with low work effort, poor motivation, socially disruptive behavior, and preferences for welfare reliance (Gilens 1996).

Another critical finding is that, contrary to previous scholarship, I do not find significant effects for social control hypotheses which suggest that state choices reflect a new regime of criminality and get tough welfare reform. As Table 4 shows, the percentage of state corrections spending does not significantly increase the likelihood of adoption. While I find evidence that family caps are negatively correlated with labor market conditions and this corroborates the seminal work of Piven and Cloward, when we look at the adoption process over time, the results suggest that Wacquant’s thesis of the supremacy of a new regime of welfare control may be overstated. This non-finding is important because previous scholarship on the punitive turn in welfare politics has argued that criminality is a key dimension for all social welfare reform efforts. The results presented here temper this claim and demonstrate that the impact of criminality may vary among welfare policy regulations.

The lack of significance related to the unmarried birth rate provides an important finding in the literature on welfare reform because cross sectional studies have found positive and significant affects. I posit that when we implement a model that accounts for time variant factors, the effects of this crude measure wash out—especially when I control for social movement strength and diffusion. In sum, these findings suggest that the strength of evangelical religiosity leads to adoptions. This reinforces the idea that punitive policy measures emanate from paternalistic social policy movements. The added value of my approach is that I disentangle the actors embedded in “conservative social movements.” Both the qualitative narrative and the results presented here suggest that punitive reforms do not originate from a monolithic conservative social movement

Repeal of Family Caps

I now turn to a brief discussion of the PEHA analysis of the determinants of family cap repeals. Seven states have repealed family caps at the date of this publication. While the number seems very small, cumulative repeals comprise 30 percent of all states that adopted the measure. This is a sizable proportion of repeals, especially when the rate of policy adoption is truly a rare event. However, when I model the “risk” of failure, my overall model is insignificant. This is due to the fact that I am working with an extremely small risk set. Remember that my data structure involves multiple failures. There are states that do not adopt, states that adopt, and states that repeal. Given the conditionality of repeals on adoptions and that rare event analysis drops state years after failures, it is difficult to test the determinants of repeals under probabilistic analytics because the risk set is very small. This is compounded by the fact that Nebraska, both an adopter and a repealer, is excluded from the analysis and Minnesota is excluded because its repeal occurred outside of the study period.

I will note that in the model for repeals, Catholic adherence rate is positively associated with repeals, which offers some anecdotal evidence that Catholic social movements “learned” that family caps promoted abortion (results not shown here). While the quantitative results are inconclusive due to the limitations of a small n, the descriptive narrative analysis suggests that progressive policy changes occurred when some social conservatives concluded that the risks of adoption outweighed the benefits. Moreover, the hazard rates suggest it is likely that more states will repeal in the future. For instance, in California liberal policy makers and an unlikely coalition between the Catholics, other pro-choice groups, and progressive advocacy organizations are actively lobbying to repeal caps in this state.

These trends imply that characterizations of family caps as representing a slanting of state activity from the social to the penal arm are somewhat overstated. The story of family cap adoption and repeals reveals that seemingly political actors can overturn punitive policies. In this way, neoliberal reforms and deregulation at the state level may actually create new spaces for political struggles to ensue within social policy. This has important normative implications because some scholars assert that deregulation only leads to a lack of democratic accountability in the U.S.

The analysis presented here also tempers explanations that imply that the welfare state is moving swiftly along a path wherein new priorities given to duties over rights, sanction over support, and the rhetoric of the obligations of citizenship characterize the poor “in a subordinate relation of dependence and obedience” (Young 2005,16). By focusing our attention on the politics of reform, even fundamentalist, punitive social movements respond to policy outcomes as they pursue new strategies or they abandon

old ones. The irony here is that the mechanisms for reform included conservative social movement actors who fought for repeals because family caps conflicted with their moral project. Indeed, the reality is that the so-called progressive efforts among Catholics and anti-abortionists have stimulated new political projects among these groups that are aimed at diverting TANF funds to promote hetero-normative marriage and abstinence only education.

Conclusion

The U.S. welfare system has been radically restructured over the last 17 years. The analysis presented here suggests that racial bias, political variables, and the presence of some social conservative movements have contributed to the adoption of family cap reforms. I also provide qualitative evidence that repeals ignited a split among conservative social movements that led some social conservatives to lobby for repeal. This chapter makes three original contributions to the literature on social welfare policy development.

First, I offer a mixed methods design to understand the determinants impacting the evolution of family cap policies in the United States. With respect to the quantitative analysis, I improve upon the impressive literature that documents important shifts in poverty governance by analyzing family caps over time through discrete event history analysis. The analytical technique used here refines our understanding of the punitive turn in social welfare policy by accounting for policy diffusion and by testing the *timing* of policy adoption. Previous studies have only analyzed policy determinants at a fixed point in time, and they have used time varying covariates to explain policy dynamics. This chapter also uses an original dataset spanning 1992 to 2010. It not only captures

family cap adoptions across the 50 states over 20 years, but it includes a number of original measures to test how the political environment and social movements influence social welfare policies.

Second, complimenting racial theories of poverty governance, I contribute to this scholarship by theorizing and testing how social movement actors influence the adoption of family caps over time. I demonstrate that the politics of family caps include political struggles between socially conservative activists, the women's health movement, and anti-abortionists. The analysis presented here demonstrates that social welfare policy reforms increasingly emanate from political conflicts that increasingly center on the regulation of poor women's bodies. The political developments leading up to the adoption of caps suggests that welfare is portrayed as a moral hazard that can trap people into a life of dependency, but as the quantitative analysis shows, this dependency is not solely related to criminality. Instead, the problem of illegitimacy emerges from medicalized political struggles that define hyper-fertility as a habit forming and pathological practice of women on welfare who are damaged as a result of the cycle of poverty. In response to these ills, family cap policies are designed to instill the necessary discipline that welfare recipients lack. Like a drug, family caps become a treatment designed to transform the lives of those who depend on welfare.

However, the findings presented here suggest that severe, punitive measures have political limitations. As the qualitative analysis shows, even the most loyal supporters were capable of altering their position when they learned about the perverse effects of this policy on abortion rates. The EHA on policy adoption also demonstrates that states learn from early innovators. In the case family caps, states became significantly less

likely to adopt this punitive policy over time. Finally, and as the hazard rates indicate, the probability of a state adopting this controversial measure is nearly zero and since 2005. Conversely, the probability of states rescinding this reform is still present suggesting that future states are somewhat likely to repeal the measure. In sum, these findings suggest the adoption of punitive social welfare policies is not inevitable. Indeed, the devolution of federal control to the states for the provision and regulation of social welfare may offer crucial openings for social movement actors to successfully undermine punitive policies.

This chapter analyzes the development and repeal of punitive social welfare policy measures. In part II of the dissertation, I widen the scope of the analysis to explore the development of early childhood policies that are primarily targeted towards low-income families in the United States. In chapters 3 and 4, I critically interrogate these seemingly progressive policy designs with a focus on the development and implementation of home visitation as a strategy to mitigate the impact of poverty on the health and education inequities among children.

Chapter 3: The Politics of Intimacy

Emerging in the late eighties, a growing network of think tanks, health and education social service providers, and advocacy organizations have mobilized around an agenda calling for investing in the development of organizations and institutions that promote significant investments in early childhood development from birth to five for disadvantaged children and their families (Heckman 2012; Shonkoff, and Fischer 2013). Proponents of these early childhood investments suggest that a major refocus of policy is required to capitalize on knowledge about the importance of the early years in disrupting inequalities and producing skills for a successful workforce (Cunha, Heckman, Lochner, and Masterov 2006; Heckman 2000; Shonkoff and Phillips 2000). Grounding their arguments in “the science of development,” policy entrepreneurs and a network of think tanks and advocacy organizations suggest that because most of a child’s brain develops by age 3, anything that inhibits positive experiences and relationships, such as the “toxic” stress of poverty and deprivation or insecure “attachment” due to maternal depression is likely to lead to poor school performance and poor adult health outcomes. Testifying before the Senate Committee on Labor and Human Resources and the House Committee on Education and Labor, David Hamburg, President Emeritus of the Carnegie Corporation of New York, made the following remarks that represent this new policy agenda:

What we do early in life lays the foundation for all the rest. The early years can provide the basis for a long, healthy life span. Early preventative intervention can be exceptionally valuable. Health and education are closely linked in the development of vigorous, skillful, adaptable young people. Investments in health and education can be guided by research in biomedical and behavioral sciences in ways likely to prevent much of the damage now being done to children... The great challenge now is to be sufficiently resourceful and persistent to find ways of putting that knowledge to use for healthy child development in a rapidly changing

socio-cultural context. If there is a more fundamental task for human beings, I wonder what it could be (Hamburg 1987, 49-50).

Proponents of this new social policy agenda have provided a framework for policy choices that focuses explicitly on enhancing positive child development in the first five years of life. Key policy interventions include promoting access to basic medical care for pregnant women and their children to prevent “threats” to healthy development; providing early and intensive support for vulnerable families through home visitation; offering high quality center-based childcare for low income families; and offering universal, subsidized pre-kindergarten education to 3 and 4-year old children. These calls to action have resulted in policy success at the federal level. For instance, the Obama administration launched a large-scale early childhood initiative that leveraged ACA funds to increase federal funding for home visitation. It also initiated the “Race to the Top – Early Learning Challenge” which funded 14 states to make significant investments in quality pre-k education and proposed multiple policies to expand access and quality in the Child Care and Development Block Grant.

Home visitation, in particular, has gained increasing traction as a key strategy to mitigate the impacts of poverty and structural racism on life chances and educational achievement across the life span. Consider this: in 2010, the U.S. Department of Health and Human Services dispersed \$100 million to states for evidence-based home visiting services—a new funding source that is one of the lesser known components of the Affordable Care Act. With annual increases, the allotment to states reached \$1.5 billion by 2014 and was extended in 2015. Estimates of total annual state allotments to home visitation range from \$250-460 million, so the federal infusion represents a substantial new source of dollars to states (Johnson 2009).

Home visiting is possibly the most personal way of delivering social services in society. Home visiting programs consist of visits from social workers, parent educators, or registered nurses to low-income families with pregnant mothers and babies at home. Home visiting is a voluntary health and education intervention in which visitors provide health check-ups and referrals, parenting advice, and guidance navigating other social services. Home visitation is fairly invasive. Home visitors typically meet with caregivers once per week and continue until the baby reaches age two, and some programs continue until the child completes kindergarten. In this way, home visitation is an ideal case study because it has been dubbed as a policy mechanism to answer progressive calls to alleviate inequities among poor children while simultaneously incorporating paternalistic and invasive strategies to monitor and intervene in the lives of the urban and rural poor. An analysis of home visitation offers the perfect opportunity to explore the tensions and conflicts surrounding the moral status of poor women and children, worldviews about the nature and effects of poverty on children, and the increasing politicization of parenthood in the United States.

This chapter analyzes the emergence of home visitation policy narrative(s) that make claims about the *nature* of educational and health disparities among disadvantaged children and proposed solutions to these inequities in the context of a U.S. welfare state that is increasingly dubbed as racist and punitive to poor women and their children. I expand the growing literature that characterizes U.S. social policy as paternalistic and punitive by investigating the extent to which home visitation policy narratives represent a continuation of this logic. Using historical process tracing, a narrative analysis of key federal documents, and an exploratory case study of home visitation service provision in

New Mexico, I describe how the infant mental health movement shaped the development of federal early childhood policy in the United States.

Social Constructions, Policy Designs, and Institutional Development

The social constructivist perspective used in this chapter builds on a growing body of research which assumes that policies are not just products of politics, but are also active forces in the political process itself (Hacker 2004; Lieberman 2001; Pierson 2004; Skocpol 1992). This policy-centered analysis is concerned not only with understanding causal studies of policy feedback; policy is also a central way to understand the center of symbolic political negotiations among competing groups in society (Schneider and Ingram 1993). Policy developments are a basis for interrogating concepts such as power, justice, and citizenship (Mead and Beem 2006; Mettler 1998; Soss 1999). Along with others, I suggest that public policy narratives function as structures that organize political action (Soss, Hacker, and Mettler 2007). As Schneider Ingram and (1993) suggest, policies play a key role in the symbolic construction of social status, political identity, and citizenship. I suggest that these constructions are essential to explaining institutional change in early childhood policy in the United States.

Policy design approaches also argue that the social construction of target groups impacts the type of policy that will be directed at the group (Ingram and Schneider 1995; Ingram, Schneider and de Leon 2007). Policy makers construct target populations in either positive or negative terms, and the designs of policies ultimately reflect these social constructions. Positively constructed groups, such as the elderly or veterans, are likely to reap benefits from policy, whereas negatively constructed groups such as criminals and welfare mothers are likely to be subject to policies that impose burdens and stigmatize

them. For example, negative media images of mothers on welfare as lazy freeloaders were used to justify strict work requirements for TANF recipients (Hancock 2004; Gilens 1996).

Social constructions of the poor are not uniform, however. Distinctions include labels such as the working poor, ghetto poor, children in poverty, welfare queens, dependents, baby mommas, baby daddies, and the elderly. What's important here is that each has its own connotation and political symbolism (Edelman 1977; Erler 2012). Despite these variations in meaning, the policy design framework also suggests that social constructions of poverty tend to fall into one of two categories: deserving and undeserving (Gans 1995; Will 1993). The key distinctions between these two groups is in their responsibility for their poverty, their orientation towards the labor market, and the acceptability of granting them public benefits. For example, deserving groups are characterized as not wholly responsible for their poverty, and they are often viewed as helpless. As a consequence, they are excused from work (i.e. the disabled), they deserve to work as a result of their service (veterans), or they have spent their lifetime participating in labor markets (the elderly). Underserving poor are characterized as having violated the social contract or the social deals made between themselves and the taxpayers who fund social service programs by participating in socially undesirable behaviors such as having children out of wedlock, drug use, and other criminal activities (Erler 2012; O'Connor 2002; Patterson 1998).

The central argument espoused by normative arguments for welfare reform is that the provision of social welfare benefits to groups that are constructed as underserving is counterproductive and dangerous with the impact of breeding laziness and dependence

(Fraser and Gordon 1994). Categories of deserving and underserving are also racialized and gendered, with African Americans and Latinos characterized as less deserving compared to other whites and other minority groups such as Asians, for example (Gilens, 2001; Iyengar 1990; Hancock 2004; Soss, Fording and Schram 2011).

While understanding the social construction of target groups aids in our understanding of how social policies like home visitation potentially construct target groups, I suggest that a limitation of this particular brand of social construction is that it de-contextualizes how historical developments, the emergence of new forms of poverty governance, and the increasing role of service provision *mediate* the developments of these categorizations. Moreover, as I will illustrate in the narrative analysis, home visitation strategies exemplify how one service strategy can contain multiple versions of how to imagine social citizenship. Contrary to the claim that paternalism is fundamentally disciplinary, I demonstrate that some actors deliberately resist punitive strategies while simultaneously enabling poor families to achieve some autonomy.

I also situate my analysis within ongoing conversations about the nature of institutional change in U.S. political development. Historical institutionalism focuses on how institutions, understood as set of regularized practices with rule-like qualities, structure action and outcomes. It emphasizes not just the development of institutions, but also how path dependency and unintended consequences from historical developments shape outcomes (Hall and Taylor 1996; Pierson 2000; Steinmo and Thelen 1992, Thelen 1999; 2004). Change is largely described as emanating from exogenous factors such as critical junctures (Collier and Collier 2002; Mahoney 2001) or by path dependencies and positive policy feedback effects (Pierson 2000). Congruent with this approach, and as the

chapter illustrates, there is no doubt that the development of early childhood policies emanates from a long historical trajectory that vacillates between a concern for social equity and practices designed to modify the behaviors of poor women.

However, since most studies from the historical institutional perspective tend to look at antecedent conditions or the nature of the historical moment, this approach can be historically deterministic, and little is said about *how policy options became understood as such among political actors* (Abers, and Keck 2013; Mehta, Béland, and Cox 2011). In analyzing the increasing politicization of parenting, I adopt a constructivist institutional theoretical framework to understand the *creation and implementation* of more recent early childhood policy designs at the federal and state level (Abers and Keck 2013; Bevir and Richards 2009; Schmidt 2008). This analysis rests on several assumptions. First, like Abers and Keck, I define institutions *as a common, accepted way of doing things* rather than relying on more prevailing definitions of institutions as rules, norms or procedures that constrain the behavior of individuals. This broader definition allows us to ask how certain ideas or practices become accepted rather than treating institutions as codified norms and practices already in existence. This conceptualization of institutions not only draws our attention to ideas, but also calls for an analysis of the concrete practices to transform *organizational resources and relationships* (Abers and Keck 2013, 3). For example, my analysis focuses on how policy narratives grow out of a combination of debates among specialists in which contested ideas are defended through political struggles and in practical experiments in particular locations (Abers and Keck 2013).

As others have demonstrated, the development and management of many policy issues also involve complex interactions among multiple governmental and

nongovernmental organizations (Sabatier and Jenkins-Smith 2003; Jordan, Wurzel, and Zito 2005). Building on this approach, I suggest that policy or issue networks are at the heart of governance in contemporary U.S. policy making (Bevir and Richards 2009; Hajer and Wagenaar 2003).⁸ Issue networks consist of governmental and societal actors whose interactions with one another give rise to policies. These actors are linked through formal and informal practices and they typically operate through interdependent relationships that are both vertical and horizontal. Most approaches to networks tend to focus on the objective characteristics of networks, stressing the scope of a subsystem or network, the relationship of the size of networks to policy outcomes, and the strategic interactions among these policy actors (Adam and Kriesi 2007; Hecllo 1978; Sabatier and Weible 2007).⁹

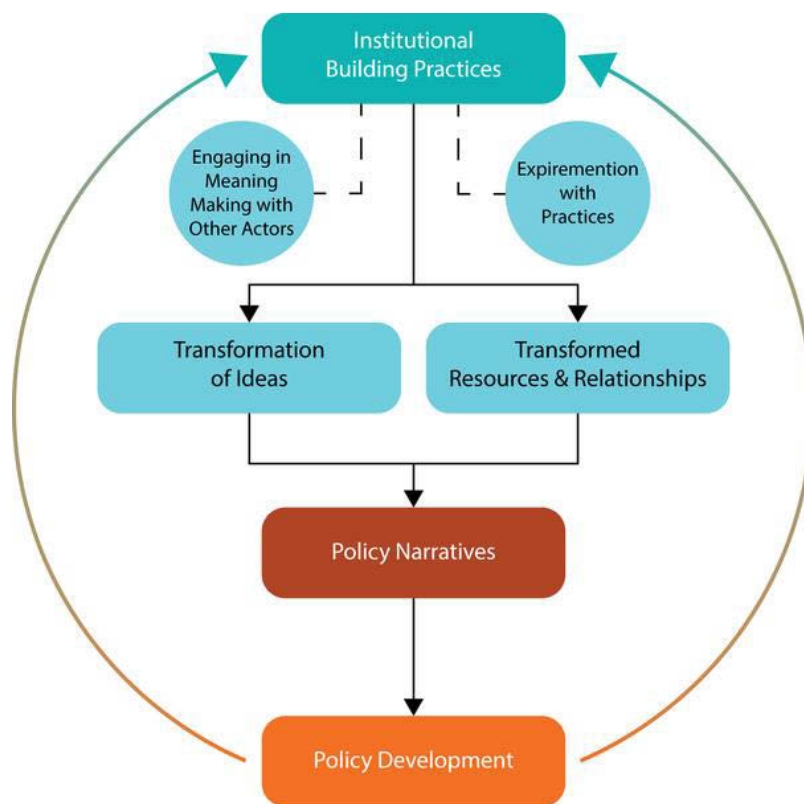
Rather than conceptualizing policy networks purely as containers of interest intermediation, I adopt a decentered approach, which treats networks as the product of contested meanings in action (Bevir and Richards 2009). Decentered theory assumes that people construct various accounts of underlying problems and solutions based on their traditions and their practical organizational experiences. Actors confront these problems

⁸ Delegated governance is a well-known phenomenon in the social policy literature. In the 1980s scholars began noting that private firms maintain a large share of the responsibility for social welfare provision in the U.S. through employer benefit systems. This “hidden” welfare state has been subsidized by features of the tax code through mortgage interest rate deductions, dependent care tax credits, and tax credits for the provision of higher education and housing (Hacker 2004; Howard 1999;). More recently, scholars have documented the evolution of the public-private divide in social welfare with a focus on health insurance benefits and through the provision of TANF. All of these social policies involve indirect government involvement to secure social welfare aims while the provision of social goods is often carried out through private for profit entities and not profit entities.

⁹ Sabatier and Weible (2014) have offered perhaps the most widely used application through their extensive work on advocacy coalitions in the United States. They argue that the policy process and change are best characterized as a number of subsystems interacting throughout the policy process. Like issue networks, coalitions represent groups with shared beliefs that coordinate activity following the emergence of a particular policy on the governmental agenda. Coalitions consist of legislators, interest groups, public agencies, policy researchers, journalists, and other actors. (For an extensive review of this theory see Weible, Sabatier, and McQueen 2009).

against the backdrop of diverse traditions, which give rise to political struggles. I trace the individuals and groups at the center of policy construction, I reveal their ideas and discourse that form the basis for collective action in home visitation intervention policies, and I explore the practices that emerge from these ideas. Figure 7 presents the conceptual framework for this chapter.

Figure 7: Ideas, Practices and Policy Development



Additionally, this chapter begins to explore how institutional change reconfigures authority relations in an era of delegated governance and federalist institutional arrangements in the United States (Morgan and Campbell 2011; Ostrom, Bish, and Ostrom 1988).¹⁰ Delegated governance refers to a broader and older political

phenomenon that has evolved since the post 1945 period. Put simply, it refers to the delegation of responsibility for publicly funded social welfare programs to non-state actors. Instead of bureaucratic agencies that assume full responsibility for distributing benefits or providing social services, collective goals are increasingly realized through private entities that include nonprofit organizations and for-profit firms (Morgan and Campbell 2011, 19). The government may finance, regulate, and oversee welfare policies, but they do not necessarily provide direct provision of many welfare benefits. This institutional context is critical for my case study because home visitation is an example of how state and federal government contract with private non-profits to deliver services in the U.S. What's more and as the analysis suggests, this private network of providers has also been influential in shaping the ideas and practices that inform the design of federal funding schemes.

Most historical accounts of social policy in the U.S. illustrate how the development of federal institutions and the politics of race and gender shape poverty governance. In this chapter, I add to the literature by describing key differences in the development of early childhood policy in the United States, with a particular focus on the politics of home visitation. Early childhood policy development shares similarities to social welfare policy development because home visitors and their funders continue to use home visitation as a project of civic incorporation for deserving and underserving mothers. A key difference has been that home visitation strategies have been mostly formulated by private foundations and think tanks, state bureaucrats, and private and public health professional experts. Contrary to other social programs such as old-age pensions or even welfare, home visitation has been historically financed, researched, and

implemented largely through private think tank foundations and a growing body of public research intuitions such as the National Institute of Health.

Until the early 2000s, there was virtually no federal support for large-scale home visitation intervention in the United States. In fact, just as the implementation of welfare reform was delegated to the state level, federal actors worked in collaboration with a growing cadre of think tanks and technocrats to consolidate control of home visitation policy through federal bureaucracies such as the Department of Health and Human Services. These institutional developments not only shaped early childhood policy and its service delivery from the outset, but they opened a policy space where professional technocrats and the science of early childhood development played a profound role in how the elimination of social inequities are increasingly reduced to individual-level health interventions focused on the micro-interactions of parents and their babies.

Finally, I suggest that the intense focus on remediating the effects of poverty in the womb represents a more fundamental shift in the meaning of citizenship in the United States. Emanating from cultural shifts in the sixties and seventies and crystalizing with the rise of the Reaganite right in the eighties, the growth of early childhood policies represents an important time when the “familial politics of the national future” have come to define the social urgencies of the present (Berlant 1997, 6). With political discourse intensely focused on abortion, reproduction, marriage, personal morality and family values, the personal has collapsed into the political to create a world of *public intimacy* (Berlant 1997). Early childhood initiatives represent a lens to analyze how the nation’s strength and value is less predicated on the success of adults than in previous years. Instead, productive citizenship is increasingly fixated on a future American who is

innocent and untainted by the ills of poverty, social disorder, and adversity (Berlant 1997, 28; Furedi 2004). The new Early Childhood policy agenda also coincides with larger sociocultural shifts in which a confessional mode of articulating social ills not only blurs the lines between public and private, but also crystalizes individuation and alienation, particularly among poor women (Fassin and Rechtman 2009; Frank, Clough and Seidman 2013; Furedi 2004). This new fixation on alleviating social ills by intervening early in life symbolizes a climate where the *internal world of the individual* is the site where the problems of society are raised and the location of where social ills need resolution (Furedi 2004).

Methodological Approach

This chapter first uses process tracing as a theory-building exercise to illustrate how home visitation policies have developed and evolved over time. I supplement this with a narrative analysis of policy documents and a thematic analysis of interviews conducted over two years' worth of immersive fieldwork in New Mexico. This allows for a highly contextualized, nuanced approach that incorporates the historical origins of policy development, provides space for the narratives within the documents to emerge, and finally demonstrates how these narratives and themes are produced and reproduced in practice in a contemporary setting.

Process tracing is an ideal tool for examining the development of these policies, as it can be used to uncover structural and macro-level explanations of the case historically (see e.g. George and Bennett 2005). Process tracing also allows for the extraction of causal inferences from within the case through the structured examination of a series of events (Waldner 2012). Theory-building process tracing, which I employ here,

is a distinct form of process tracing, and is described by Beach and Pedersen (2013) as well as Rohlfing (2013). While analyzing the historical sequence of events methodologically, I have also maintained a theoretically grounded perspective, which provides a solid framework from which to establish a theory specific to this case.

The interpretive lens that I employ here draws out the social constructions of policy practices by considering how individuals create and act upon meanings about the causes and solutions for educational and health inequities among children. In short, this inquiry is less about predicting or generalizing behavior and more about interpreting intention and meaning in context (Dodge, Ospina and Foldy 2005; Shank 2002).

In order to articulate the emergence of skill-based and medicalized discourses about state intervention in health and the public health perspective, I analyzed over 40 key national level policy documents and speeches from leading think tank research centers, official reports from the Department of Health and Human Services, and some Congressional testimony (See appendix B for details). I analyzed documents and speeches from 2010-2015 and selected reports that have been repeatedly cited as seminal to the early childhood field. Additionally, after mapping the major advocacy organizations, bureaucracies, research councils, and think tanks working on home visitation and early childhood policies, I selected documents and speeches from these key entities.

I used interpretive narrative analysis to understand two central questions. At the federal level I explore the following questions. First, how do key actors and organizations within the early childhood policy world describe maternal and child health inequities? And second, how do they frame the culprits of inequities, and why do they suggest that

home visitation is a remedy to cure these social ills? At the state level, through an exploration of the development of the childhood policy network in New Mexico, I examine how some local policy actors both conform and resist these larger narratives. Through the collective stories of participants involved in shaping statewide policies and through the experiences of four private not for profit home visitation agencies, a rich picture of the tensions between support for community capacity and empowerment with individual, behavioral based intervention strategies emerges.

In the second stage of the analysis, I excerpted textual stories verbatim from the documents. I then used the anatomy of the stories to create abstracts that were literal condensations of each story (Jones and Radealli 2015; McBeth, Jones and Shanahan 2014). Since my goal was to discover worldviews, I allowed the categories to emerge from the data. Next, I iteratively sorted through these abstracts and grouped similar responses together to create a comprehensive set of categories for early childhood policy narratives. Finally, I coded each story to explore in depth and uncover strategically constructed stories about the underlying causes of inequities in children's health and school performance and the desired solutions to these ills.

Finally, the interview data presented in this chapter emanated from a broader National Institute of Health funded pilot project that analyzes the ways that home visitation programs in the state of New Mexico variously construct systems of social support, and promote community empowerment to improve school readiness. The research team, including myself, used participant observations, ecological case studies, interviews, photo ethnography, and focus groups to compare and contrast variations in

the actual practices of home visitation in rural and urban areas in New Mexico.¹¹ To analyze the interviews, I used standard inductive coding techniques to generate key themes for the analysis. The themes uncovered in the interviews were analyzed to explore how national narratives were produced and reproduced at the local level. This process bolsters the validity of the narratives and the theory that was constructed using process tracing. The themes generated from the interviews also illuminated how local actors resist skill based and therapeutic policy interventions.

The Historical Development of Home Visitation Policy in the U.S. Home Visitation as a Strategy to Improve Environmental Conditions

Across time, people have received various forms of care in their homes from family, friends, and neighbors. The roots of home visiting in the United States can be traced to Elizabethan Europe where visitors provided care to the poor in their own homes. Home care was most often prompted by conditions of illness, poverty, and poor living conditions (Astuto and Allen 2009; Katz 1986). Prior to the institutionalization of health care with the development of hospitals, home care was the dominant mechanism for delivering rudimentary health care to individuals.

As a more formal practice, home visitation has long roots as a social advocacy strategy dating back to the 1890s in the U.S. (and much earlier in Europe). Responding to the growing visibility of urban poverty in cities such as New York, local community advocates, a growing network of public health nurses, and home visitors collaborated with research institutions and social service agencies to combat the poor living and working conditions of the urban working class (Wiess 2006). These workers conducted

¹¹ This included 13 interviews with program administrators and state policymakers and 5 focus groups with over 47 recipients of home visitation services.

social surveys in cities that were endowed with industrial capital and an increasingly immigrant and nonwhite working class.

These advocacy strategies were intertwined with a new objectivist approach to social sciences and institution building around poverty in the United States. A key development that supported this approach to understanding and correcting poverty was made possible by the arrival, in the first decade of the twentieth century, of large scale, corporately organized private philanthropy (Lagemann 1999; Sealander 1997). A small number of general purpose foundations dominated as did the names of famous industrialists such as Andrew Carnegie and John D. Rockefeller. For example, the Russell Sage Foundation was founded in 1907, and it identified its mission as principally one of social investigations to improve social and economic conditions (Lagemann 1999). Distinct from earlier periods, this approach to understanding and intervening in urban poverty was vigorously empirical, devoted itself to devising more and even better scientific methods of gathering, categorizing, and analyzing the social, and it sought to serve the institutional building objectives of the burgeoning array of social settlements, philanthropies, and professional and civic groups. For example, social surveys became a key strategy to understand social ills (O'Connor 2002.)

The most famous examples of this method occurred in large cities such as Chicago, Philadelphia, and Pittsburgh (O'Connor 2002). This widespread effort is relevant because it produced a framework in which poverty was investigated as a problem of political or social economy. Social workers, nurses, and progressive advocates suggested that low wages, long hours, and hazardous work conditions contributed to poor living conditions which harmed the life chances of the urban poor

(Sealand 1997). Critically, these early actors unsuccessfully recommended policies and practices which focused on the distribution of income and wealth in cities, improving labor conditions, and providing wider access to early education for poor women and their children (Minkler and Wallerstein 2015).

Home visitors were pivotal in these efforts because they provided the conduit from community to home. Indeed, friendly visitors who were middle and upper class women were charged with the task of penetrating urban, poor, and immigrant communities in an effort to offer moral and behavioral guidance as well as to report back to their superiors about the “nature of the living poor” (Katz 1986). Often called “experts of urban survival” (Katz 1986), home visitors linked families to communities, in part a role still critical in home visitation today (Astuto and Allen 2009). In short, home visitation was an outreach strategy of an emerging groups of progressive social investigators that sought to extend the boundaries of antipoverty thinking to issues of industrial democracy, political reform, and trade union organizing (O’Connor 2001).

Alongside the emergence of private philanthropies that were interested in characterizing the lived experiences of poverty by mapping the environmental conditions of the poor, the growth of the public health nurse movement and the birth of social work reinforced these efforts. With a strong commitment to improving neighborhood conditions and the “hygiene” of poor mothers, the term community organizing was coined by social workers in reference to their work in coordinating services for newly arrived immigrants and the poor (Minkler and Wallerstein 2015). For example, influential texts such as Mary Richmond’s 1903 book *Friendly Visiting among the Poor: A Handbook for Charity Workers* declared that “the ‘friendly visitor’ does not apply to one

who aimlessly visits the poor for a little while, without making any effort to improve their condition permanently or to be a real friend to them” (Richmond, Mary 1912, Preface, pp. v).¹²

The establishment of settlement houses, the kindergarten movement, and the promotion of compulsory public education also stimulated the practice of using community and home visits as an outreach strategy (Mink 1995). Advocates believed that the quality of neighborhoods directly affected the welfare of children. Consequently, community visits were combined with home visits to create a more holistic environment for childcare. For example, schools used home visiting teachers to promote compulsory school attendance policies (Mink 1995). The efforts of these home visitors were grounded in a pervasive view that environmental conditions significantly influenced personal problems and diseases (Minkler and Wallerstein 2012). The conditions were often associated with urbanization and immigration, poverty, contagious diseases, infant mortality, and school dropouts. The influence of this movement represents a product of a time when boundaries between public and private and between policy domains were not sharply drawn. This network of charities, philanthropies, and public health nurses slowly extended its reach to push for local neighborhood improvement, city planning, environmental clean-up, child welfare, and labor protections.

¹² Additionally, Richmond continued to influence the practice of home visitation through her concept of the social diagnosis, which visualized the connection of the client and their social environment. She identified six sources of power that were available to both social workers and their clients: resources within the household; in the client; in the neighborhood and wider society; in civil agencies, and in public and private agencies.

Infancy Protection, Maternal Reform, and the Production of Good Citizens

While these progressive aims propelled home visitation in the early 20th century, a racialized and increasingly technocratic approach was also adopted as maternity policies became more formalized through the formation of the U.S. Children's Bureau in 1912. Linda Gordon (1994) and Gwendolyn Mink (1995, 1998) point out that one of the primary purposes of these maternal policies was to facilitate the cultural assimilation of Southern and Eastern European immigrants into an American, middle class model of parenting. Rejecting scientific ideologies that defined cultural differences as inherited and immutable, reformers "sought to create one motherhood from diversely situated women" (Mink 1995, 10). A key development was the emergence of the Mother's Pensions Movement which created cash payments to widows with young children (Skocpol 1992). Mother's Pensions were part of the Progressive era awareness of the environmental origins of poverty and the necessity for state intervention to insure economic and social justice. In practice, however, states extended Mother's Pensions with the condition that widows conform to medical norms regarding child rearing and "American" family standards. Home visitors ensured that children would be nurtured to worthy citizenship.¹³

In 1921, with the passage of the Sheppard-Towner Act¹⁴ which aimed to structure the provision of maternal and child health services, nurse home visiting became a component of the federal health infrastructure (Thompson et al. 2001). The act appropriated \$1.9 million to support local infant welfare work, and the appropriation

¹³ The experience of Latinas was more mixed and was often contingent on the region, local labor markets, and the citizenship status of the local Latino population. Importantly, Fox finds that the extent of reformer paternalism was far less in regions like the west and southwest as growers relied more heavily on migrant workers who were non-citizens.

¹⁴ The Sheppard-Towner Act Maternity and Infancy Protection Act offered federal assistance to set up educational services for expectant and new mothers at the state level.

offered matching grants to states that adopted maternity protection plans. It created a Federal Board of Maternal and Infant Hygiene to implement its provisions. The act legitimated infant welfare work and expressed the nation's commitment to "save the babies." Assuring Congress that the Sheppard Towner Act did not promote maternity benefits, one of its key architects, Julia Lathrop, explained that infant mortality problems were not fundamentally caused by economic instability (Ladd-Taylor 1994). In fact, she and others argued that cash benefits were not the solution to poor infant health outcomes. Instead, the female authors of this legislation claimed that the protection of infants required preventative interventions with education of mothers by nurses, teachers, and social workers (Ladd-Taylor 1994; Mink 1995). In short, that act represented maternalist strategies to treat family problems by support interventions that disseminated advice, instruction, and supervision. According to Lathrop:

It is not to get the Government to do things for the family. It is to create a family that can do things for itself, it is to get parents who know what their children need, who are good and wise and can secure a decent living; who know when they need a doctor and will have him; who will know when they need public health and will help to pay for it gladly; and who know what kind of a school they want their children to go to, and will help to create that and pay for that. (Lathrop, Hearings on the Public Protection of Maternity and Infancy, Quoted in O'Connor, 241-242).

The act, however, did not standardize infancy protection measures, and it allowed states to determine the content of local initiatives. Some states refused to cooperate whatsoever, others emphasized demonstration clinics, some prioritized midwifery, and others used the money to train and deploy home visitors (Astuto and Allen 2009). The key point here is that the passage of this law institutionalized home visitation as an optional maternal child and health policy that would continue to remain under the

purview of states and private philanthropy. As a result, the development of home visitation occurred unevenly across states, and this influenced the course of home visitation until the late nineties. When home visitation was a policy priority, it was primarily used to address the health behaviors of poor communities (Buhler-Wilkerson 1985). Home visitors emphasized cultural reform and visiting nurses taught mothers more scientific and more American standards of hygiene and care. For instance, and as Mink (1995) points out, home visitors were preoccupied with issues such as the immigrant diet and its effect on digestion and health. In fact, the Children's Bureau established cooking classes for immigrant women under the Smiths-Hughes act of 1917, and providers taught mothers the dangers of spices and foreign vegetables (Mink 1995).

As formal training in psychiatric social work expanded, the social reform movement that emerged in the beginning of the twentieth century retracted. Increasingly, professional nurses and social workers were the primary educators for poor mothers, and they focused their efforts on issues such as breastfeeding and hygiene (Katz 1986). The main purpose of these visits was to provide in-home education and health care to women and children who lived in urban, poor contexts (Buhler-Wilkerson 1985; Astuto and Allen 2009). Maternity policies privileged medicalized hospital births; assumed women needed to be trained for motherhood; and connected parenting training to the unlearning of cultural practices deemed unhealthful by reformers and physicians (Mink 1995).

Funding for maternity and infant care was short lived, however. The Sheppard Towner Act was repealed in 1929 amidst concerns about socialist policies that interfered in the lives of families. By the time the act expired, every state but one had established an MCH unit. Many states continued to provide training even though there was no longer

adequate funding until 1935 when State-Federal cooperation re-emerged in Title V of the Social Security Act. Title V became provided the foundation for all federal initiatives related to health for mothers, children and youth, and children with special healthcare needs (Margolis et al. 1997).

The Early Formation of the Infant Mental Health Movement

After World War II, U.S. institutions became increasingly pre-occupied with concern over social adjustment and well-being in the postwar era (Nolan 1998; Herman 1995). According to Ellen Herman, “it was understood that mental health was necessary to the efficacy of the Armed Forces in the short run and national security, domestic tranquility, and economic competitiveness in the long run” (241). Reflecting this mind set, the National Mental Health Act was passed in 1946. A key piece of this legislation was the creation of the National Institute of Mental Health (NIMH) which grew at a phenomenal rate. For example, in 1950 the agency’s budget was \$8.7 million, but by 1967 its budget was \$315 million. Moreover, in the 1960s the NIMH was spending more money on psychological studies of disease of behavior than on conventional medical research on the biology of mental illness (Nolan 1998, 231).

Another critical medical development in the social work professions and the mental health field was the influence of psychoanalytic theories that emphasized the role of individual responsibility rather than the social environment in determining behavior (Coll et al. 1996). The basic principle of dynamic classification was to link neurotic with normal behavior and to classify both as variations in common developmental processes. This blurred the distinction between normal and neurotic, yet it maintained the bifurcation between psychotic and all other behaviors (Horwitz 2002, 41). Neuroses

stemmed from universal childhood experiences, and the difference separating normal from abnormal behavior were only matters of degree. The diffusion of this way of thinking is evidenced in both the growth of formal psychological institutions and practices. From the late sixties until 1983 the number of psychologists grew threefold (Nolan 1998).

In addition, Eva Illouz (2008) masterfully argues that ego psychology became a bridge between the science of psychology and the conception of selfhood that began to take shape in American culture by the mid-fifties. At its core, she argues that this brand of psychology suggested that the idea of “becoming” is never static: an adolescent is different than when she was a child and from what he or she will be in adulthood. Consequently, its supporters claimed that it is the individual’s responsibility to realize many of his or her own capabilities in order to live an authentic life (Illouz 2008, 43) This new view of psychology penetrated popular culture through the advice literature in books and magazines, through the diffusion of new genres of daytime television such as soap operas and daytime talk shows, and through the exponential growth of advertising (Illouz 2008, 51-55).

I suggest that the ethos of ego psychologists also formed the ideational basis of the infant mental health movement. The key point here is that this perspective identified a new category of people who did not conform to the ideals of self-fulfillment *as representing those who are “sick.”* (Illouz 2008, 44). As a result of this discursive shift, health and self-realization became increasingly synonymous. Illouz (2008) concludes that the effect of putting self-realization at the center of health is that this made *most* peoples’

lives unself-realized. As a result, this circular logic elevated the authority of psychologists to be purveyors of a healthy society (Moskowitz 2001).

Based on this mindset, throughout the forties and fifties, a newly emerging child-development community began to explore the process through which developmental outcomes were affected by the child-rearing environment. Guided by a psychoanalytic framework, a series of natural experiments focused on the effects of institutionalization on the cognitive and social emotional development of infants (Provence and Lipton 1963; Spitz 1945). These studies documented the destructive impact of sustained isolation and under-stimulation in hospitals and orphanages (Spitz 1945).

On a conceptual level, the work of John Bowlby provided the theoretical framework for the empirical findings of these early deprivation studies. Under the auspices of the World Health Organization in the 1950s and 1960s, Bowlby studied the problems of homelessness and maternal deprivation and examined their consequences for mental health in children in places from Africa to clinical institutions in Great Britain. Crowned the father of “attachment parenting,” Bowlby defined attachment as a deep and enduring emotional bond that connects one person to another across time and space (Ainsworth 1973; Bowlby 1969). Bowlby proposed that attachment should be understood under an evolutionary context because caregivers provide safety and survival for the infant. Attachment is adaptive because it enhanced the infant’s survival, and according to this line of thought, attachment is universal and exists across cultures. Bowlby’s work and subsequent popularity among clinical interventionists was critical in the development of more recent constellations of home visitation interventions in that he called attention to the importance of the mother-child relationship for healthy child development (Shonkoff

and Meisels 1990). He wrote “mother-love in infancy and childhood is as important for mental health as are vitamins and protein for physical health” (Bowlby 1952, 158).

Building on the work of attachment clinicians from the fifties and sixties, medical professionals increasingly adopted a fierce dedication to analyzing how the micro-dynamics of mother-child relationships contribute to emotional and cognitive deficiencies as children grow (Horwitz 2002). In psychiatry, guided by the work of Renee Spitz, a new paradigm stipulated that the “traumatic” infancies led to pathologies later in life which in turn affected the economic mobility and life chances of poor minority groups (Fitzgerald and Barton 2000). The work of Selma Fraiberg and her colleagues in Michigan was a pivotal turning point in shaping public rhetoric about child development (Zeanah 2009). In 1972, Fraiberg established the Child Development Project at the University of Michigan. The project’s goal was to develop a psychotherapeutic home visitation model of intervention for mother and infant dyads.¹⁵

Fraiberg argued that infancy offered a unique opportunity for promoting mental health. Attachment-based interventions were seen to have the potential to support healthy development, improving long term outcomes, and ameliorating the damaging effects of maternal mental illness (Paris et al. 2009). As a result of her early work, home visitation interventions increasingly comprised a range of strategies focusing on relationships through emotional support, resource assistance, development guidance, advocacy, and infant-parent psychotherapy (Weatherston 2001).

Also through the work of Mahler and her colleagues, the field of psychoanalysis began to incorporate direct observations of infants and their mothers into research and

¹⁵ In 1958 Fraiberg’s *The Magic Years* focused public attention on the early years of development as over 1 million copies of the book were sold over a 15-year period (Fitzgerald and Barton 2000).

clinical practice (Horowitz 2002). Using experimental techniques and videotaping, clinical researchers began to test how conditions of stress and interaction patterns between mothers and their infants produced suboptimal behavioral reactions in infants such as poor self-regulation and depressive symptoms (Fitzberg and Barton 2000). These practices underscore how surveillance medicine became increasingly fixated not only with illness, but with the apparent precarious nature of health (Lawless, Coveney and MacDougall 2014). Infants became the object of new concern as attention turned to the “uniformed mind of the child” (Armstrong 1995, 396). Acting as the public face of this new movement, Fraiberg noted that when social policy or law did not acknowledge the primacy of infant-child parent relationships, it was the duty of mental health professionals to speak for children and their right to “implement practices that can in themselves prevent damage to countless numbers of children (quoted in Emde 1983, 442).

In sum, the growing support for intervention policies aimed at modifying the child rearing techniques of poor mothers represented a process in which their parenting problems were increasingly defined in medical terms. As the professionalism of home visitors grew, nurses, social workers, and psychologists became the proper authorities to “treat” poor women and their children. Especially pertinent to home visitation was the growth of the infant mental health movement among clinicians, psychoanalysts, service providers, and health professionals in the seventies and eighties.

The Crystallization and Diffusion of the Infant Mental Health Movement

In 1973, bureaucratic advocates of the infant mental health movement in home visitation intervention convinced Fraiberg to train individuals in community mental

health agencies as a strategy to implement infant mental health services throughout Michigan (Shapiro, Adelson, and Tableman 1982). Beginning with 12 individuals, The Michigan Association of Infant Mental Health formed in 1977, and the membership of this private nonprofit grew quickly (Fitzgerald et al. 2011). By 1977, over 800 community providers had participated in this training and were implementing this approach throughout the state. Similar to other membership-based professional associations, the Michigan AIMH established the *Infant Mental Health Journal* as their official publication. Still in existence, the journal focuses on caregiver-infant interactions, conditions placing infants at risk, infant development outcomes, and self-regulation (Fitzgerald and Barton 2000).

Perhaps most importantly, the Michigan Association of Infant Mental Health worked diligently to spread its efforts throughout the states by assisting like-minded professionals to form their own statewide associations. By 2014, 27 states had formed infant mental health associations that emulated this model (Fitzgerald and Barton 2000). What's more, the Michigan AIMH remained at the epicenter of working with other national associations such as Zero to Three to create a vast credentialing system that certifies a range of social service providers to provide different levels of infant mental health interventions throughout the health and social services sector (Fitzgerald et al. 2011; Weatherston, Kaplan-Estrin and Goldberg 2009). With the help of Zero to Three, the Michigan AIMH copyrighted its training and continues to provide technical assistance to other statewide associations to train and assist in promoting infant mental health interventions.

This development was critical because throughout the nineties the infant mental health movement worked at the state level to build program regulations that required infant mental health specialists to supervise and manage an array of early childhood services, including home visitation. By creating a vast credentialing system, a new cadre of “infant mental health professionals” proliferated throughout the United States. As home visiting became a popular policy solution for poverty reduction in the 2000s, both federal and state funders increasingly stipulated that early childhood systems of care use infant mental health professionals to manage the clinical work of lay and professional home visitors (Interview August 2015).

Alongside these developments at the state level, the National Center for Clinical Infant Programs was founded in 1977 by professionals in medicine, mental health, social science research, and child development. This professionally based membership group (which later became Zero to Three) was launched with financial support from the National Institute of Mental Health. The explicit purpose of Zero to Three was to organize and train researchers and practitioners working with infants and their children. By the 1980s, the organization established its own non-peer reviewed journal as a device to disseminate best practices and training in the field of early childhood intervention.

In 1994, after a 10-year effort, the organization published the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3). Similar to the adult DSM, this controversial manual provided a developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers. Beginning at the age of three months, it contains a range of diagnoses including pathologies such as post-traumatic stress disorder, infant depression,

infantile anorexia, feeding disorder of caregiver infant reciprocity, and mixed disorders of emotional expressiveness to name a few.

This clinical guide and their agenda surrounding attachment parenting gained political authority throughout the 1990s through multiple advocacy efforts by Zero to Three. These strategies included advancing substantial professional training programs with early childhood professionals, launching a national campaign called the “Magic of Everyday Moments” funded by Johnson and Johnson, and establishing a policy center in 2000, which now contains over 40,000 members (Zero to Three 2016). With the help of key democrats in the mid-nineties, including First Lady Hillary Rodham Clinton, Ted Kennedy, Chris Dodd, and John Kerry, Zero to Three began to secure several multi-year and multimillion dollar contracts with the federal government to design and implement early childhood programming that would be diffused to the states through a series of federal grant initiatives from the 1990s to the present (Zero to Three 2016). For example, Zero to Three was selected to launch and operate the National Early Head Start Resource Center which provides all educational assistance and program development for home visitation and childcare grantees, it operates the National Infant Child Care Initiative to provide guidance and support to child care administration throughout the states, and it recently won a major contract funded by the Substance Abuse and Mental Health Services Administration to be the focal point for early childhood systems development for state, tribal, and community based early childhood services.

The Behavioral Sciences Revolution in American Think Tanks

A second major development that contributed to new understandings and solutions to poverty emanated from the behavioral sciences revolution. Spurred by

government agencies and private philanthropic funders, there was a vast expansion of resources and institutional infrastructure for behavioral research in the post-World War II era. Carnegie, Rockefeller, Russell Sage, and the newly endowed Ford Foundation virtually invented the label behavioral research and proclaimed it the new frontier of social investigation (Lagemann 1989; Herman 1995). In conjunction with two new postwar federal creations, the National Institute of Mental Health and the National Science Foundation, these private foundations had a lasting impact on the future of social research, and they fostered a link between research and policy development. One indicator of their impact on research institutions was reflected in the proliferation of institutions devoted to interdisciplinary research, including university based research centers.

The social movement behind behavioral sciences sought to reorganize social knowledge around individual and group behavior and called for objectivity and methodological rigor in order to gain acceptance by the scientific establishment and the ideological right. Two key methodological innovations were used to accelerate the growth of this kind of knowledge production. First, this era spawned the application of quantitative sampling, measurement, and predictive modeling techniques to survey individual attitudes and behaviors. Second, especially in clinical fields such as psychology, social scientists began to use social experiments to understand the casual structure of human behavior (O'Connor 2002).

The evidence of the influence of the behavioral movement is clear in the substantive methodological innovations that emerged. Studies of early childhood became a growth industry in the social sciences and researchers explored questions ranging from

individual development to cross-cultural comparisons of child rearing around the world (Hermann 1995). In the United States, the sociological study of class faded, and a new emphasis was placed on the family as a source of class-typed personality differences that would determine an individual's opportunity in life as well as the character of nations.¹⁶ Indeed, this liberal embrace of an individualized psychologically oriented approach reinforced the emerging consensus that major social problems could be resolved without political mobilization or significant institutional or economic reform.

The practice of home visitation also increasingly became entrenched in the emerging policy context which favored evidenced-based policy interventions.¹⁷ While the origins of evidence-based practices in the early childhood field can be traced back to their roots in medicine, home visitation advocates used this growing consensus to bolster home visitation as a viable policy solution to decrease the effects of poverty on educational and health outcomes among children. A key development for reawakening the national interest in home visitation came when a group of researchers in Colorado began to test how home visitation could potentially improve health and developmental outcomes among first time "at risk" mothers in cities. In 1977, David Olds began randomized control trials with a program soon to be known as the Nurse Family Partnership (NFP), which supported the use of nurses in the homes of poor families with children from birth to two (Astuto and Allen 2009). NFP is a nurse home visitation program that targets first

¹⁶ One of the most poignant examples of this is when Theodor Adorno developed a statistical method for linking personality traits, social attitudes, and political ideology to determine the psychological roots of anti-Semitism, prejudice, and fascism and the social conditions under which authoritarianism could flourish (Adorno et al. 1950).

¹⁷ One of the key policy entrepreneurs in this area was Archie Cochrane who launched evidence-based medicine in the 1970s in the UK, primarily through the use of randomized controlled trials in the evaluation of treatment approaches and by using systemic reviews and meta-analyses of clinical research.

time, “at risk” mothers who are pregnant, low income, unmarried, and often teenagers. While focusing on this particular target group, NFP requires that its services take place in community settings that have high access to medical and social services. Critics of the model suggest that by selecting communities with structural supports, NFP has biased results because it does not serve the highest need mothers because NFP requires that local communities undergo a screening process to ensure that they have adequate social, economic and health resources within the community to support first time mothers. By only selecting communities with adequate levels of support, NFP excludes the poorest areas that lack public infrastructure and community capacity. This selection criteria potentially inflates the impact of NFP on child and maternal health outcomes.

Using a highly structured curriculum, the program works intensely with mothers both during pregnancy and for the first two years of life. According the model, “treatment” begins during pregnancy, when nurses make weekly visits to the home with curriculum designed to improve women’s diets, help women monitor their pregnancy weight gain, eliminate the use of cigarettes and drugs, and educate expectant mothers about labor and delivery. In the post-partum period, nurses teach mothers about the involvement of the family and friends in the early care of the infant and support of the mother and to provide linkages to other health and human social services. The NFP was evaluated in randomized control trials in Elmira, New York (1977), Memphis, Tennessee (1988) and Denver, Colorado (1994). These trials showed improvements in prenatal health, birth outcomes, and child development (Olds et al. 1986; Olds et al. 2002; Olds 2006). Additionally, there is evidence that NFP contributed to reductions in child abuse and crime (Olds et al. 1986).

The development of the NFP had a clear impact on federal policy making by the nineties and early 2000s. In effect, the NFP became widely touted as the gold standard for new approaches to evidence-based policy making. Enacted on March 23, 2010 as part of the Affordable Care Act (health care reform), the Maternal, Infant and Early Childhood Visiting (MIECHV) program provides \$1.5 billion in mandatory funding to states, through formula and competitive grants, to implement or expand evidence-based home visiting programs for at-risk families. States must use 75% of their allocations to support program models designated as evidence-based, such as Nurse-Family Partnership, with up to 25% of funds available to support promising programs demonstrating some effectiveness (Center on the Developing Child 2007). Nurse-Family Partnership (NFP) provides ongoing consultation to states that have selected NFP as part of their MIECHV state plans and, to date, 43 states have elected to use NFP as their home visitation model supported by federal funds (Nurse Family Partnership 2016).

The Politics of Intimacy

Just as clinical psychology and evidenced-based practice permeated health and social provision, the sixties and seventies also marked a new era in which social norms about marriage and intimate relationships underwent significant transformation (Cherlin 2009; Seidman 2013). In the social and political sphere, the large scale entry of the women in the workforce, the reduction in the average number of children per family, and the extension of the time couples spend together shifted from the family as an institution designed to raise children and foster economic security to one in which the family serves as a vehicle to satisfy the emotional needs of its members (Cherlin 2009; Seidman 2013). As Seidman (2013) cogently argues, marriage began to shift from being a state-enforced

legal and moral entity that was socially compulsory to a private association of two equal persons seeking self-fulfillment and intimacy (Cherlin 2009; Coontz 2007; Seidman 2013). Although family remained at the core of social organization, individuals came to be seen as entitled to freely form and dissolve relationships. According to Seidman:

Although erotic relationships are forged and valued for a variety of reasons such as romantic love, economic security, social status and family making, their ultimate value today, for many Americans is as sites of intimacy. For many Americans too, intimacy is the chief staging ground to realize a life of self-fulfillment along with a sense of secure belonging (2013, 22).

In contrast to previous normative orders of marriage, relationships now rested on the bedrock of communication, ongoing negotiation, and deliberation about household tasks, sexual practices, and career priorities. As a result, individuals increasingly began to assume responsibility for their own personal governance. But as a normative force, this discourse of intimate relationships compelled individuals to share their interior lives, to communicate their needs and desires, and to be emotionally capable of entering and exiting relationships without falling apart (Cherlin 2009).

These broad scale social and economic changes were also precipitated by U.S. political institutions. Between the 1880s and the 1950s the state intervened in specific and far reaching ways to enforce the marital ideal of heterosexual, racial, gender scripted, and male-dominated marriage as the primary site of adult sexual intimacy (Cohen 2004). However, beginning in the late 1960s and 1970s, U.S. legal and economic institutions steadily recognized the private sphere of decision making, especially related to issues of sexuality and intimacy. For example, in a series of supreme court decisions, the courts paved the way for the precedent that citizens deserve legal protection from arbitrary state

interferences through juridical outcomes such as *Griswold vs. Conn.* (1965); *Eisenstadt vs. Baird* (1972); and *Roe vs. Wade* (1973) (Cohen 2004).

While intimate relationships became an expanded field of choice among the middle class, the dialectic of “intimate freedom” was distributed unevenly in the United States. As white, middle class women began to enter the workforce in the late sixties and seventies, they were able to purchase domestic labor, daycare, good schools, counseling, health care, and legal services for their families. Indeed, an indicator of the class politics of intimacy is reflected in the fact that college educated Americans began to marry at higher rates compared to low income women (Cohen 2004). Moreover, as a product of their educational success and access to financial resources, middle class parents cultivated the cultural resources that enabled their children to acquire the dispositions and capacities to be skilled at fostering “healthy relationships.” In a double whammy, the institution of marriage gave middle class adults’ access to public institutions to manage their internal conflicts related to divorce and child custody. Less educated Americans, in contrast, began cohabiting at higher rates and increasingly bore children out of wedlock. The result was that low income Americans began to rely on provisions such as AFDC to underwrite their support systems, which were becoming ever more stressed and composed of informal networks of siblings, lovers, and friends (Seidman 2013). Already burdened by a deflation of their status as the result of working in low income and low prestige jobs, the ideal of intimacy stigmatized the relational patterns of the poor as lacking the egalitarian ideal of ‘healthy relationships.’

While national programs like Head Start were designed to improve the social and economic circumstances of the deserving poor, changes in marital and childbearing

patterns, the urban crisis of the sixties, and the overrepresentation of African Americans on Aid for Dependent Families (AFDC) also heightened concerns about parental fitness and the excessive fertility rates of the underserving poor (McCann 1999; Luker 1996). Reformers originally conceived of AFDC as a temporary band aid to help support needy widows and their children until sufficient numbers of working fathers were covered by other insurance plans designed to protect their families when they died. However, social and economic circumstance changed both the numbers and the types of women and children enrolled in ADFC. For example, in 1960 only 80,000 families were receiving assistance, but by 1965 the number increased by 25 percent with over one million families receiving assistance (Luker 1996). By the early seventies, over 2.2 million families were enrolled in AFDC. What is more, the typical family on welfare was no longer headed by a widow. She was the sort of mother, unwed, divorced, or deserted, that had historically been seen as unworthy (Luker 1996; Soss, Fording, and Schram 2011).

In 1947 about half of all single mothers in the U.S. were widows, another third were married women who had been deserted, and the remaining 20 percent were divorcees. By 1970, the population of AFDC recipients had changed radically: 20 percent were widows, more than half were divorced or separated, and seven percent had never been married (Luker 1996). The changing structure of the American family, the entrance of white women in to the “pink” labor force, and the migration patterns from the south to urban centers in the North had a noticeable effect on African Americans. With the range of occupations still fairly narrow for Black women, disinvestment in urban cities, and their ineligibility for Social Security, Black women became increasingly overrepresented in one of the few social insurance programs open to them: AFDC.

This was exacerbated by changes in marital and childbearing patterns that would soon characterize all Americans, but became apparent first among African American women. After World War II, African American women were almost as likely to live in two parent families, but Black out of wedlock births began to increase in the sixties (Luker 1996; Soss, Fording, and Schram 2012). By 1970, 16 percent of all Black mothers had never been married compared to 3 percent of whites (U.S. Census 1980). Increasing divorce rates and out of wedlock births translated into a public discourse that called attention to a perceived crisis in the escalating birth rates among African American women, and by the late seventies, discussions about poverty began to take on a distinctive racial tone.

Perhaps the clearest example of the transition from an academic discourse to the politics of social policy came through the well-known efforts of the late Senator Daniel Patrick Moynihan (D-NY), author of *The Negro Family: The Case for Nation Action* (1965), more commonly known as the Moynihan Report. Building on a new line of thinking called the culture of poverty, Moynihan, then a member of the Johnson administration, cited the work of sociologists and psychologists that attributed poverty to the pathological structure of the Black family. Moynihan stressed that the Black family structure included mothers that were too strong and who prevented Black fathers from assuming their rightful role as head of the family (Murray 1993). As a result, Black men suffered a loss of self-esteem and personal efficacy while Black women were too busy trying to be breadwinners. As a result, poor Black mothers suffered from a sexual identity that was either frigid or promiscuous. What really made this a perpetuating cycle was the distorted psychological development of children. Without a strong male figure, they were

left to turn to delinquency for immediate gratification and release (O'Connor 2002). As the report stated, "*a considerable body of evidence to support the conclusion that Negro social structure, in particular the Negro family...is in the deepest trouble*" (italics in the original Moynihan 1965). The report continued, "...**the family structure of lower class Negroes is highly unstable, and in many urban centers is approaching complete breakdown**" (Moynihan 1965). According to this discourse, dysfunctional child rearing and disturbed gender family relations were the mechanism that transmitted low academic achievement and poverty from one generation to the next.

Salma Fraiberg echoed these sentiments in her famous study titled "Ghosts in the Nursery." In her iconic book, Fraiberg used the device of case histories to elucidate the pathologies of poor families and the power of home visitors to heal vulnerable families.

According to Fraiberg, Adelson, and Shapiro (1975):

It was a story of bleak rural poverty, sinister family secrets, psychosis, crime, a tradition of promiscuity in the women, of filth and disorder in the home, and of police and protecting agencies in the background making futile uplifting gestures. Mrs. March was the cast-out child of a cast out family. In late adolescence, Mrs. March met and married her husband, who came from poverty and family disorder not unlike her own. When these two neglected and solitary young people found each other, there was a mutual consent that they wanted something better than they had known. But now, after years of several effort, the downward spiral had begun... (392).

These broad discussions about poverty were consequential for multiple new social policy interventions and a renewed desire to search for intervention policies that would monitor and regulate the individual behaviors of poor women. With respect to reproductive health, public aid for contraceptives was virtually non-existent prior to the sixties.¹⁸ When poor women were having unwanted, out-of-wedlock births and when

¹⁸ Indeed, there were estimates that at least 5 million poor women were in need of publicly subsidized family planning services.

unwanted babies seemed to be bloating welfare rolls, architects of the war on poverty began to argue that preventing pregnancy was a key first step in reducing and preventing poverty. According to Joseph Kershaw, the OES's first Assistant Director of Research, "We looked into family planning with some care and were amazed to discover that it is probably the most single cost effective anti-poverty measure" (Quoted in Luker 1996, 59). Under the auspices of the Office of Economic Opportunity, the federal government initiated a small effort to fund birth control for poor women, and by 1970, with full bipartisan support, Congress extended its commitment to birth control and passed the Family Planning and Population Research Acts. The legislation created the Office Population Affairs and the National Center for Family Planning Services (Luker 1996). It instituted Title X of the Public Health Services act that became the largest source of federal funds for contraception until the nineties.

Fighting poverty with the pill marked a new era in poverty governance. Federal policy makers embarked on a new policy agenda that steered away from addressing how the dynamics of class, labor market relations, and racial segregation reproduced poverty among racial minorities. Instead, they became fixated on finding policy solutions that were likely to control undesirable behaviors among poor women and their children. Federal policy makers found themselves searching for policy solutions that were attached to the health behaviors of this "new" urban culture that presented a stark contrast to the growing affluence of the white middle class.

Narrative Analysis of Policy Documents

As the late nineties approached, public health and infant mental health advocates promoted a policy discourse that increasingly used medical metaphors to describe how

social and economic conditions penetrate the poor like a disease. Indeed, the late 1990s saw attachment theory gain new impetus through neuroscience research linking early life experience with brain development. In 2000, the National Research Council (NRC) and the Institute of Medicine (IOM) released the landmark report, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. The key message of this report was that “early experiences determine whether a child’s developing brain architecture provides a strong or weak foundation for all future learning, behavior and health” (Center for the Developing Child 2007). This report unleashed widespread interest and funding for neurological research that sought to understand how stress in early childhood is either “growth promoting or toxic to developing brain architecture and physical health” (Center on the Developing Child 2007).

This policy narrative emphasized that poverty is detrimental because it damages the emotions of those who live with it, and these adverse circumstances induce stress, trauma and various forms of mental illness and poor cognitive development among fragile families. According to Deborah Phillips, the coauthor of *Neurons to Neighborhoods* at a keynote address to the Child Care Development Block Grant in 2010:

Toxic stress is defined as the strong, unrelenting activation of the body’s stress response systems in the absence of the buffering protection of supportive adults. These situations can include physical or emotional abuse, chronic neglect, severe maternal depression, deep poverty substance abuse or neighborhood or family violence. Without the support of a caring adult, toxic stress can disrupt brain architecture...Call it dysregulation, call it reactivity. Call it hard to manage. It’s very damaging to the brain. Toxic stress is also damaging to the body and to the heart and soul of a child (Phillips 2010, 5).

Science now tells us that there are physical consequences of relationships in the early years and that environments are responsible for neural sculpting. Not only do the early years shape the brain, neuroscience suggests that an opportunity missed is an

opportunity lost. According to the Harvard Center on the Developing Child in 2007, “Toxic stress in early childhood is associated with disruptive effects on the nervous system and stress hormone regulatory systems that can damage developing brain architecture and chemistry and leads to lifelong problems in learning, behavior and both physical and mental health” (10). The implication here is that these critical windows for brain development, once passed are closed and forever lost.

This scientific discourse of risk supposes that risk is identifiable, objective, and based in science (Lawless, Coveney, and MacDougall 2014). Social problems are increasingly classified as *risk factors* that modify, ameliorate or alter an *individual's* response to externalized environmental hazards. The dysfunction of poverty is that it predisposes distressed families to maladaptive behaviors and outcomes. Key here is that the root causes of class and racial inequities are increasingly framed as externalized factors that penetrate individual behavior and the biological development of innocent children.

For example, Sir Michael Marmot, a leading worldwide public health advocate and researcher, makes the case for new policy interventions that engage in “equity from the start” by portraying poverty as a “toxin” that inhibits the successful biological and social emotional development of innocent children. According to Marmot (2015)

Where we to find a chemical in the water or in food, that was damaging children's growth and their brains worldwide, and thus their intellectual development and control of emotions, we would clamor for immediate action... Yet, unwittingly perhaps we do tolerate such a state of affairs. The pollutant is poverty or, more generally lower rank in the social hierarchy, and it limits children's intellectual and social development. We should want it removed as if it were any other toxin, so that children can develop their potential... You might blame adults for their absentmindedness in being poor, let alone what you see as their disgraceful behavior in risking their health by eating cheap food... Fecklessness, it has been

called, or being of the underserving poor—but don't blame the children! They do not choose their parents; they do not choose to be born in poverty (112).

Echoing these claims, the National Child Traumatic Stress Network argues that poverty, crime, low academic achievement, addiction, mental illness, and chronic disease all have roots in “untreated childhood traumatic stress.” Stress takes many forms, but it is particularly sobering that physical and mental health disparities among poor and ethnic minority groups continue to be a glaring reality. According to a policy brief published by this policy network, “Among the factors contributing to this situation the prevalence of violence must be emphasized as a social toxin that poisons the quality of life and derails the healthy functioning of millions of children and their families. Infants and toddlers are disproportionately affected because the first 3 years of life are critical” (The National Child Traumatic Stress Network 2014, 2). For this early childhood social movement, the silver lining is that “every year, billions of dollars are spent in the United States to address the serious consequences of ignoring this public health problem.” (The National Child Traumatic Stress Network 2014, 4).

The culmination of this fundamental shift in poverty governance was the passage and implementation of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA). Just as welfare reform took shape, early childhood intervention policies also provided the perfect solution for managing poverty in the U.S. because they were also premised on providing behavioral interventions that sought to reform poor mothers. Indeed, after years of consolidation, a policy network of foundations, think tanks, and government bureaucracies crystalized and worked diligently at the federal level to fund a number of new early childhood initiatives including home visitation.

Early childhood policies were politically palatable because they conformed to the neoconservative critique that the urban poor represented the demise of the nuclear family, but they also offered liberals the opportunity to distance themselves from the more punitive aspects of welfare policy reform. Democrats, in particular, aligned around this agenda to strengthen families as a countermove to leftist critiques that welfare reform penalized racial minorities and stigmatized poor mothers. In fact, beginning in the early 2000's, Democrats began to leverage federal funds and TANF dollars to fund home visitation, child-care subsidies, and other resource interventions for parents. Similar to conservatives, liberal supporters for policies like home visitation suggest that dependence on the state for direct financial or material support is problematic, and the role for government is to generate opportunities and resources that encourage moral responsibility among citizens (Gillies 2005). From their perspective, the increasing numbers of children living in poverty could be addressed by ensuring that their parents were 'supported' to meet their obligations and provide for their children.

Perhaps one of the most striking illustrations of this mentality is the widespread appeal of skill based solutions for investing in early childhood stimulation and nurturing for disadvantaged children. James Heckman, the Nobel Laureate in economics and expert in the "economics of human development" has been at the forefront of this approach with substantial support from Pritzker Children's Initiative.¹⁹ According to this skill based narrative, child poverty is not solely determined by the income available to families. It is most accurately measured by parenting resources: the attachment, guidance, and

¹⁹ The Pritzker Initiative is a private philanthropic organization led by J.B. Pritzker who served as the national co-chairman for Hillary Clinton's (D) presidential campaign in 2008 and became an active supporter of President Obama in the 2008 election.

supervision accorded to children. According to Heckman, while delivering a speech at a White Conference in December 2011:

There is no question that cognitive abilities are important determinants of socioeconomic success. However, there is decisive evidence that socio-emotional skills—physical and mental health, perseverance, attention, motivation and self-confidence—are as important as predicting success in life...A major research finding is that the accident of birth is a primary source of inequality. Parental recourse, skills and abilities matter greatly...Taking the long view, Americans can most effectively address inequality in society with a strategy of predistribution---by enriching parenting resources for young children in disadvantaged environments, not by redistributing income to adults.

As he states, the essential elements for successful childhood include engaged, supportive parents. Thus, policy interventions should provide parents with information and resources for providing a stimulating home environment. And this is where home visiting programs come into play. They foster parental attachment, positive interactions, and a greater parental investment in children (Heckman 2011).

In the late 1990's, no federal funding specifically for home visiting was appropriated in the United States. States or localities that did recognize the advantages of home visiting had to piece together funds from a variety of state and federal sources to serve small numbers of families. In short, home visiting programs were challenged by the instability of their funding sources. For home visitation advocates, an immediate consequence of this situation was the inability to build strong implementation models. Moreover, by the early 1990s, it became clear that home visitation was not well understood as an important and valid service delivery method.

Consequently, organizations such as Zero to Three: The National Center for Infants, Toddlers and Families convened key leaders in the home visitation movement to strategize about how to increase federal support for this early childhood policy.

Importantly, this and other early efforts were funded by support from private foundations to reach an agreement on the definition of home visitation; to review existing research; to establish that a stronger evidence base was needed to categorize promising practices; and to reach some consensus on elements of home visitation. An important milestone in this process was that the coalition agreed that home visiting was not a particular program or service. Instead, they agreed that it was a “strategy for offering information, guidance, and emotional and practical support directly to families in their homes” (Margie and Phillips 1999).

From Narrative to Practice

In the previous section, I demonstrate how the infant mental health movement and a politics of intimacy contributed to the ascendancy of home visitation intervention as a favorite policy choice in a paternalistic policy environment following the major restructuring of the welfare state. As my theoretical framework suggests, discursive frameworks have the effect of situating home visitation with a policy narrative of risk, interpersonal relationships, and the attainment of skills. In this section I analyze interviews conducted in the field that highlight some of the home visitation techniques and practices that have regimented these ideas.

Reflective Supervision

One of the key organizational strategies of the infant mental health movement has been to hardwire the practice of “reflective supervision” into the organizational infrastructure of emerging early childhood institutions. The primary focus of reflective supervision is “the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and

supervisors and practitioners” (Weatherston and Barron 2009, 63). This practice is entrenched in the idea that quality social service delivery hinges on “partnerships” between supervisors and supervisees. Through dense interpersonal relationships and weekly supervision sessions, the idea is that supervisors and home visitors develop trusting relationships by attending to the emotional content of the work and how individual reactions to this content impacts interactions with children and their caregivers. According to Barron and Paradies (2010), two leaders in the field:

Reflective supervision allows the IMH home visitor to sit with another and think deeply about a particular infant and family and their responses and needs. When the IMH home visitor enters into the supervisory relationship, making herself vulnerable and sharing feelings and thoughts may be difficult, she begins the journey much in the same way as parents and babies. She shares her vulnerabilities with another, experiences a new way of being with another, and maintains respect for herself and her professional growth. The experience is then passed along to the parent, so that the parent can do the same for the infant (42).

Detailed competency guidelines endorsed by state infant mental health associations have worked painstakingly to develop core areas of expertise such as contemplation, self-awareness, curiosity, professional and personal development, parallel process, and emotional response as necessary for the delivery of effective quality early childhood programs. Key among these concepts is an exploration of the parallel process, which suggests that attention to all relationships (parent and child, practitioner and parent, and practitioner and supervisor) sets the tone for positive development among vulnerable children. As Barron and Paradies (2010) continue:

Parents with past histories of early relationships that were absent, unstable, inconsistent or conflicted may treat the IMH home visitor as a maternal figure, or the home visitor may put herself in that role. The parents see the potential to develop unique supportive relationships, which may lead to positive changes in the way they form a relationship with their infant (40)

The diffusion of the practice of reflective supervision is clearly evident in the current early childhood policy scene. In New Mexico, for example, state and federally funded home visitation programs require that all home visitors receive reflective supervision from an internal clinician or by designated providers that receive additional funds to monitor program compliance throughout the state (Interview July 2015). In fact, the state bureaucrat responsible for implementing the public statewide system in the late 2000s required that all personnel, including data technicians who manage electronic records of visits and screening, be trained in this approach. According to the state official:

The relationship is key. I required that all of our statewide trainers and home visitors had to be trained in work that is completely relationship focused to help home visitors to understand the power of relationships. How we treat each other, how respectful, how genuine that we are going to be with you and your baby is key. We are sitting and observing and that creates a way of looking at supporting relationships that is not intrusive and is respectful. This creates curiosity for the parent. For example, when the parent is doing something that is not so good like, if the parents thinks that putting their face really close to the baby and the baby is trying look away to self-regulate, we say something like, 'What do you think the baby is doing when he moves away?' The parent can reflect and reflect the capacity of their behavior. Reflection in the infant mental health world and psychology has been proven to be key in moving parents away from thinking that everything is about them (Interview August 2015).

The intense focus on relationships is reinforced by direct home visitation service providers as well. According to the manager of the largest statewide home visitation model in New Mexico:

Everything is about relationships, it is about the relationship, it is about the relationship that the home visitor has with the family, the mother of the daddy, if he's involved, and the baby... It's relationship, relationship, relationship and that's what, I mean that's what, you know I've done human services for all these years, that's what works you know? No matter what people say, it's about the relationship.... And the relationship evolves, you, are almost like, you are not a family member, but you sort of are because you start to know the family and you know the extended family (Interview June 2015).

Reflective supervision also provides a mechanism to contain women who face a number of adversities related to poverty, “risky behaviors” and what professionals deem “trauma histories.” Home visitation is viewed as a strategy to unearth deeper problems and to prevent adverse experiences among children; however, as the clinical gaze of infant mental health deepens, intervention increasingly requires the expertise of clinical professionals. According to an executive director of a clinical, evidenced based, program in New Mexico:

We have a lot of high risk women who will reveal things you know about their trauma histories and it's like what does it mean to deliver a baby when you're the victim over time of sexual trauma? Like your body is not you know, so there's guidance around those topics. There's also built in what they call reflective supervision for the nurses and so that they and the state programs all require this as well, it's been a mandate of the state, but as you know, but that you know we don't expect the nurse to deal with the, you know, the treatment of that trauma. And so what we've done here is we've built in access to some of our psychologists and early childhood mental health folks, so that at very least you can get a consultation if you're blown out of the water by something somebody tells you in a home visit (Interview March 2015).

Interviews and document analysis also suggest that this form of social provision requires mental fitness among home visitors. Indeed, leaders in the field suggest that unless the home visitor is an expert in intervening with psychologically at risk families, intervention from a mental health professional is critical (Harden 2010). Through a complex system of consultations, training, case conferences, and observations, concepts of poverty and social exclusion are increasingly detached from the practice of home visitation (Gillies 2005). Instead, the quality of parenting is identified as the key factor enabling young children to cope adaptively with “adverse environmental circumstances” (Lieberman and Osofsky 2009). Additionally, lay workers increasingly serve as translators from the home to the clinic and the environmental circumstances of poverty,

social exclusion, and hyper marginality are increasingly erased from social provision.

According to the executive director of the oldest community based home visitation program serving Latino families in the poorest areas of New Mexico:

Everything's turning to infant mental health. It can only be done by people up here and can't be done by people down here and it can only be a short visit and it can only be clinical. And we used to have a definition which is family, training and support and it allowed us to work with families in a very holistic way and we could do home visits. Well, now that money's gone. It's gotten narrower and narrower.... Think about it, what got cut by 90%? Environmental risk (Interview March 2015)

The practice of reflective supervision illuminates how the infant mental health movement has penetrated home visitation practices. Through self-reformation, therapy, and a dedication to adjusting the micro-dynamics of parenting, citizens are asked to adjust themselves by the techniques propounded by mental health clinicians. Through weekly interactions with visitors, this mode of self-governance reinforces the idea that citizens recognize themselves as potentially ideal people capable of creating self-fulfilling lives. Yet, the process also evokes a normative judgment about what women are or could become and the possibility of rectifying these shortcomings through the advice of experts. The irony here is that making reflexivity and our interior existence central to social provision suggests that low income families must simply choose this "freedom."

Risk Assessment

Poverty is increasingly viewed as a risk factor that reduces the capacity for positive learning as low-income mothers and their children face a barrage of needs that need to be filled. Perhaps the most explicit way in which this idea has become institutionalized is by the proliferation and use of "risk assessments" in home visitation. As the vocabulary of risk acts to position mothers as either positive factors in fulfilling

their children's potential or as harmful agents, the practice of parenting has become about individual behavior and individual choices. Indeed, a key function of home visiting is to employ a variety of risk screenings to triage the needs of vulnerable mothers and to assess if parents need more advanced clinical interventions. This practice has been implemented in state-run home visitation programs in New Mexico. In 2013, the Legislature passed the New Mexico Home Visiting Accountability Act. The Act defines the Home Visiting System, establishes a common framework for service delivery and accountability across all programs, and outlines expectations for annual outcomes and reporting (NM Center for Education Policy and Research, 2016). The Accountability Act codified a home visiting system that existed in some form since 1989 and was increasingly unified under the leadership of the Children Youth and Families Department which is a department with the Human Services Division.

Rather than adopt a single model of home visiting, CYFD led a process to create a standards-based Home Visiting System that was flexible enough to allow home visiting programs to respond (at least in theory) to community specific needs, but it established program standards and benchmark programs of all individual home visiting contractors. The linchpin of this framework rests on an intricate system of risk screening that requires home visitors to screen parents and children for risk factors related to physical and socio-emotional development, maternal physical health, domestic violence, maternal depression, and positive parenting interactions. As Table 5 indicates, these screening tools exemplify the process of honing in on the socio-emotional dynamics of parenting, the emotional health of mothers, and the developmental functioning of infants. Clearly missing from this list, however, are tools that allow the home visitor to gauge how

structural circumstances such as joblessness, poor living conditions, unsafe neighborhoods, and social exclusion contribute to difficulties in parenting pattern

Table 5: Required Screening Tools for State Home Visitation Programs in NM

Screening Tool	Description
Age & Stages Questionnaire -3 (ASQ - 3)	Parent questionnaire used to identify infants or young children who are in need of further assessment in five domains of child development
Age & Stage Questionnaire: Social/Emotional (ASQ-SE)	Aids in identifying young children who may benefit from more in-depth evaluation and/or preventive interventions designed to improve their social competence, emotional competence, or both
Edinburgh Postnatal Depression Scale (EPDS)	Used to identify women at risk for prenatal and perinatal depression
Maternal-Child Health Form (MCH)	Information regarding demographics and risk factors for the family and child
Perinatal Questionnaire (PNQ)	Information regarding an infant's birth including prenatal care, birth weight, and mother's experience with pregnancy
Parenting Interactions with Children: Checklist of Observations Lined to Outcomes (PICCOLO)	Observational tool for tracking and supporting parenting interactions that lead to positive child outcomes from infancy through preschool
Relationship Assessment Tool (RAT)	Used to identify caregivers experiencing emotional and/or physical abuse in their intimate relationships
Woman Abuse Screening Tool (WAST)	

These surveillance mechanisms are not only required to achieve funding, but the state has invested in a sophisticated electronic data system in which home visitors enter the scores from the respective screenings that are required at different points of service delivery.

Using processes of reflective supervision, the clinical director of the state-funded home visiting program works with the data management team to conduct regular audits and to use the data as a communication loop between home visitors and state officials (Interview

June 2015). Indeed, when home visitors are overdue in administering a required screening they get an email about it, they receive emails when a key piece of data is missing, or when at “at risk” screen has not resulted in the proper referral. The mantra of the New Mexico state model of home visitation is to use home visitation as a mechanism to monitor, screen, and refer women who present risks to the healthy development of newborn babies. According to one home visitation manager describing the Ages and Stages questionnaire:

We use the ASQs because that helps us measure whether or not children are reaching developmental outcomes. It is also the tool that the state uses so use that if there are issues and challenges then we make referrals to the Family Infant Toddler Program for assessment and determination about whether or not that delay, or perceived delay I should say, is significant enough to require intervention by that program. It does not at that threshold then we, we monitor and continue to monitor (Interview June 2015).

This logic is echoed by a nurse home visitor who focuses on the physical and health aspect of home visitation:

We’re weighing the baby, we’re checking on breastfeeding, we’re taking the mom’s blood pressure. We’re kind of seeing where she’s at because usually by the third week you come and moms in pajamas, right. She’s tired. She’s been up all night for several nights and, um, sometimes postpartum... so we also do assessments... I mean, there’s a lot of assessments and the reason is, right, it’s the evidence-based model. So during pregnancy where we’re collecting information and then infancy is really the bulk of what we’re, um, we’re kind of collecting a lot of information on that first year of life. (Interview March 2015).

In addition to these health and developmental screening tools, the majority of screening seeks to uncover risk factors that highlight mothers with unresolved trauma which make the “ghosts in the nursery” come to life during pregnancy and infancy. The point here is that screening is an essential tool to unlock how trauma may have enduring effects on pregnancy wellbeing and the intergeneration transmission of risk. In a subtle way,

screening the mother is viewed as a protective strategy meant to ensure that infant's developmental trajectories are not hijacked by the need to make sense of trusted adults to keep them safe. According to the clinical director of an evidenced-based home visitation program:

So the social emotional screenings really tells us like the baby will tell us a story if we're listening and they can't tell us with words, but they can tell us with behavior. So social emotional screening will kind of give us a link into something's going on, if things are... the behavior's really out of order check or whatever... maybe the, the child is experiencing violence. Like it may not be happening to them but it might be happening to the person that they love and they're saying this is not okay. So you learn more about infant development (Interview March 2015).

On the surface screening for risk factors can be a helpful tool in preventing child maltreatment and developmental delays and in forging positive bonds between mothers and children. However, by fixating on individual dysfunction, home visitation practices potentially simplify complex issues and shape our understandings of social problems. This risk vocabulary places mothers in the precarious situation as either positive factors in fulfilling their children's potential or as risks to the potential development of good citizens.

Points of Resistance

The analysis suggests that the medicalization of poverty inscribes poor women as traumatized people in need of treatment. Rather than political-economic reform, mental health services and practices like home visitation have become key to attacking the poverty in poor neighborhoods (Schram 2000). As John McKnight (1995) argues, medicalization not only disables and positions those in poverty in a subordinate position of helplessness, but it is individualizing and it reinforces the idea that social problems should be attacked at the point of the individual.

But is this picture as bleak as it seems? At least in New Mexico, there is evidence that there are points of resistance to this clinical way of engaging with mothers. For example, while community based home visiting programs incorporate the requirements of screening and the infant mental health approach into their programming, they also engage a variety of practices that seek to promote community development and political advocacy for stigmatized populations. In addition, the directors of these place-based home visitation programs firmly situate the experiences of the populations that they serve within structural social inequalities. According to the Executive Director of a public health-based home visitation program located in the urban center of the largest city in the state:

So it's poverty in all these areas. So I think it's a combination of cultural factors and then the influence of economic disadvantages and inequalities that, that lead to some of these problems. So what I'm saying by that is that in this country we have some of the most significant inequalities than the rest of the world. So there are the haves and the have nots, that gap is huge. It's getting bigger. I think that experience of being in the same country and the same city where there is a small group of have and a large group of have nots, creates a dynamic of well a sense of injustice, inequalities and then brings out a lot of anger and I think it leads to violence in other ways, in multiple ways, not just physical violence. Uh it's just that sense of well it's unfair, there's injustice... (Interview May 2015).

Clearly the administrator of this home visiting program recognized the impact of more distal influences on the lives of individuals or the social determinants of health.

A lay home visitor who delivers services to Latinas and other refugee populations reinforces this line of reasoning when she describes the living conditions of the area she serves:

In this neighborhood, it smells different, looks different, feels different because when you drive here there's not a lot of green areas, there's not a lot of stores, and everyone is on top of each other. You walk in the neighborhood and you see the housing, the smell, and everything that is happening and you just think how can we make this a better place for families that live in this area. Brand new families

that are brought over here through the department, the refugee families, the immigrant families, and you place them here and then you start, when I start thinking about um why is the purpose of really having the immigrant population here, living in these subsidized, horrible condition housing and no one is really doing nothing (Interview September 2015).

Contrary to other depictions of poverty, this characterization situates the “problems of parenting” within social inequities that lead to community deprivation and violence. Put simply, this description suggests that poor communities can be depressing places to live in, residing there can be traumatic, and life in an impoverished area is simply hard.

Another program manager explained that following an evidence-based curriculum to foster skills among mothers is nearly impossible when mothers struggle to make ends meet. In her own critique of their previous adherence to an evidence-based model she states:

But, but it’s so important that if we’re gonna, have to meet families where they are and we weren’t meeting them where they are. You know how are you gonna think about whether you’re reading to your baby or your baby isn’t crawling if you don’t know how you’re gonna pay your rent at the end of the month or they’re turning the electricity off. You can’t expect people to sit and read to their baby when they don’t know what, if they’re, if they don’t have lights to use at night to read to the baby, come on let’s be real. It doesn’t work that way (Interview June 2015).

To meet these conditions, home visiting programs like these use a number of tactics to improve the living conditions and community capacity in the areas they serve. For instance, one home visitation program is housed in a community health center that undertakes a holistic approach to delivering social and medical care in a poor, urban area. In addition to offering comprehensive wrap-around services to its families, which are mainly immigrants, the program collaborates with other community agencies and advocacy organizations to foster community development in this depressed area. For instance, the program works with a legal advocacy organization to provide free legal

assistance to immigrants and refugees. They also worked with other community advocates to make an effort to change the image of the neighborhood as the “warzone” to the official name the “International District” to deliberately create a different image of the area and to attract investment. They lobbied to change zoning regulations and for safer streets with adequate lighting, and they worked on a federally funded project to promote the community through public art.

In another key instance, a local community based home visitation organization partnered with the local business community, a variety of social service agencies, and the criminal justice system to simultaneously offer intensive home visitation and an economic development initiative for formerly incarcerated fathers and their families. Specifically, the initiative worked with the local business community to employ and train formerly incarcerated fathers in a variety of job training initiatives, including woodworking, auto detailing, and truck driving while simultaneously providing home visitation, case management, counseling services, and access to a therapeutic preschool.

Practices like these suggest that while federal narratives and many state-level home visitation programs conform to a disciplinary logic, there are several community-based agencies that resist this narrative completely. Instead they use a mix of individual-level strategies, community-level action, and political advocacy to work at multiple levels to confront poverty, poor living conditions, and the social circumstances that impede parents’ abilities to cultivate ideal environments for their children in which they can thrive.

Conclusion

The political developments described in this chapter have far reaching political implications. I demonstrate how private philanthropy, think tanks and a growing infant mental health movement shaped the content and discourse of evidence-based early childhood policy development in the United States. The process tracing of early childhood policy development in the U.S, deepens our understanding of paternalism by widening the scope of social policy analysis and unpacking the rationale and influence of health based social movements on poverty governance in the U.S. Applying a discursive institutional framework, I demonstrate how the politics of intimacy permeated the organizational practices of public home visitation through the institutionalization of reflective supervision and risk based assessment at the state level.

I provide strong evidence that these early childhood narratives are medicalized and premised on middle class parenting practices. By pathologizing the poor, these narratives potentially stigmatize vulnerable families by suggesting that mothers are the main risk for perpetuating poor health and educational outcomes in their children. Yet, using Foucault's fundamental insight, (1980) the disciplinary power of these policy narratives instigates resistance among some local actors.

Chapter 4: The Practice of Home Visitation

As chapter 3 elucidates, the political relationships and material practices of early childhood policy delivery have changed dramatically in the past twenty years. The analysis presented here extends the social policy literature on neoliberal poverty governance by exploring the organizational and home visitation practices of a New Mexican home visitation program, Families United. The chapter explores three primary research questions. How do socially situated bureaucrats navigate the complexities of poverty, social isolation and building parental capacities with families? What role do early childhood and health intervention programs play in either disrupting or perpetuating social stratification? Do neoliberal and evidence based organizational practices influence how front line bureaucrats address structural inequities?

This chapter is divided into three sections. In the first section, I outline the theoretical premise of the chapter by defining the normative implications of paternalism and by describing how social service agencies are capable of enabling autonomy; by providing a conceptual distinction between organizational strategies that are activist verses organizations that conform to a new politics of performance management and community building; and by articulating how paternalistic social service delivery organizations may contribute to spatial stigma in marginalized communities. The second section describes the research design and the ethnographic methods of the chapter. Finally, the third section discusses the research findings with three levels of analysis. The first part of the analysis interrogates the advocacy and community building strategies of Families United to explore the extent to which they advocate for structural reforms aimed to improve health and social inequities. The second part of the analysis describes the

organization practices of the agency. Finally, the third level of analysis employs participant observation to explore the micro-dynamics of home visitation to assess the extent to which Families United conforms to the disciplinary logic of paternalism or whether it invokes practices that enable the autonomy of families and their children.

New Paternalism

New paternalism is a philosophy of social service delivery coined by Lawrence Mead. According to Mead, the aim of social policies for the poor should “attempt to reduce poverty and other social problems by directive and supervisory means” (Mead 1997, 4). Welfare policies are paternal because they attempt to alleviate poverty through directive and supervisory means, they presume that the poor lack the competence necessary to manage their affairs, and the new paternalism emphasizes civic obligations as a justification for behavioral expectations and it seeks policy arrangements that make the extension of social rights contingent on the fulfillment of state defined social obligations (Soss, Schram and Fording 2011). For instance, welfare recipients must earn their cash benefits by participating in a variety of workfare activities such as professional development training, they are subjected to fertility and childrearing techniques that dissuade welfare mothers from reproducing additional children, and welfare reform policies suggest that paid work is a primary source of value in the vast majority of citizen’s lives (Ben-Ishai 2012). In this way, paternalism is a project of civic incorporation that seeks to rehabilitate people such as the homeless, drug addicts, and unmarried teen mothers who do not “display the minimal level of self-control expected of decent citizens” (Wilson 1997, 340-41). As chapter 3 outlines, the policy narratives of U.S home visitation increasingly cling to a paternalistic logic which suggests that

pathologies from parents' past and low parenting skills are the root causes of inequities in children's health and educational attainment.

Community Based Organizations and Service Delivery

Consistent with the devolution of the social welfare state, local governance is increasingly carried out through partnerships between public, private and nonprofit sectors. Community organizations, urban improvement activities, and organizational relationships are changing as well (DeFilippis, Fisher and Shragge 2010). State and private funders display a growing emphasis on technical expertise, "best practices", and the demonstrable achievement of outcomes. What's more, an increasing number of community organizations receive a significant portion of their operating funds through contracts to deliver local state-service programs from philanthropic agencies. Consistent with broad trends, the structure of community organizations dedicated to early childhood has shifted toward professional organizations with expanded budgets, greater ranges of activities, and a number of paid staff (Skocpol 2003; Stoecker 2003; Walker 1999). Stoecker (1997, 2004) contends that this has resulted in a shift from a community organizing approach to a community development approach which limits organizations from working toward wider goals and constrains agencies to primarily focus their efforts on individual level service provision.

According to this argument, this devolution of responsibilities is not accompanied by sufficient resources nor any actual power to shape the political agenda for social policy development. For many, the push towards policy making and service provision to the local level is a means by which the neoliberal state has co-opted community organizations into their agenda (Peck 2001; Raphael 2008; Soss, Fording and Schram

2011). For these scholars, poverty governance has become more organizationally dispersed, more muscular in its normative enforcement and firmly rooted in the market logics of performance, profitability and competition (Soss, Fording and Schram 2011). Social service provision has been reorganized to reflect the principles of “the new public management,” a reform movement that has replaced traditional, rule based authority tactics with market-based competition tactics (Kettl 2002). For example, contracts with private providers are increasingly used to proliferate market incentives for efficiency and innovation (Dias and Maynard-Moody 2007). Through sophisticated information systems, agencies monitor frontline activities and measure priority outcomes. As a result, “choices are generally limited to the specific means that will be used to pursue mandated ends and are shaped by strong performance measures and incentive structures” (Soss, Fording and Schram 2011, 204). This market dominated approach to public policy has been among the factors leading to health and social promotion being reduced to an emphasis on individual behaviors such as parenting, tobacco use, diet, physical activity, and job skills (Raphael 2008). Scholars point to the troubling reality that economic inequalities have reached levels not seen since 1928 as evidence that these institutional developments have only worsened health and social inequities.

On the other hand, other scholars argue that greater financial capacity, flexibility, and the expanded agendas of large community based organizations increases their ability to implement positive changes in their communities and actually gives them a louder voice in local and state politics (Bright 2003; Smock 2004). Devolutionary governance provides new venues for participatory decision making and empowerment through mechanisms such as developing community advisory groups and by promoting increased

service coordination among local providers and advocacy organizations. Indeed, government agencies, philanthropic organizations and policy makers often characterize these institutional developments as opportunities for increased community participation, community level empowerment and positive social change. While the reality of community empowerment does not match policy rhetoric (DeFillipis, Fisher, and Shragge 2010; Robertson and Minkler 1994), there is evidence of movement in this direction on a number of fronts. Over the last three decades, community-based organizations and coalitions have arisen to mobilize and fight environmental racism, food insecurity, HIV/AIDS, the targeting of minorities and youth by tobacco and alcohol industries, and cutbacks in social services for vulnerable groups (Minkler 2012). For example, in her examination of Coordinated Community Response of domestic violence, Ben-Ishai (2012) suggests that the coordinated efforts of domestic violence shelters, local law enforcement, clinical providers, the legal system, and victim advocacy groups forged critical policy changes such as mandatory arrests, the coordination of services in the community, and the overall shift of domestic violence from the private to the public. Systems advocacy continues to be a critical part of ensuring that changes made in the legal system actually provide safety for survivors of abuse. In sum, these kinds of projects have leveraged inter-sectoral collaboration and high levels of community participation to achieve policy reforms that have impacted the creation of healthier cities and communities (Corburn 2009).

As chapter 3 demonstrates, community agencies also increasingly rely on knowledge politics (Elwood 2006) as an arena to negotiate their role and power in policy development and service provision. Community agencies make choices about what kinds

of knowledge to present and how, with the objective of influencing decisions or bolstering their agenda. In the realm of early childhood, expert knowledge has dominated policy decision-making through quantitative cost analyses, randomized control trials, brain mapping, and observational studies that are leveraged to gain support for resource allocation and evidence based, behavioral interventions. To a lesser extent, some locally based home visitation programs undertake a more organic approach by working with marginalized communities to use local knowledge in ways that enhance their ability to advance their own priorities and agendas.

In sum, community organizations have been depicted as subject to state controlled imperatives that mandate the appropriate intervention strategies for improving child health and educational outcomes or as enacting resistance to dominant practices by producing their own local meanings and strategies to mitigate the impact of poverty and poor child health. Simply stated, the role of community organizations and service delivery providers has been framed as either activism / resistance or as service delivery on behalf of the neoliberal, paternal state. Discussions of the role of knowledge politics follow a similar bifurcation. Community organizations are either depicted as producing experiential knowledge or as reinforcing dominant, expert knowledge.

There are several shortcomings with conceptualizing the role and power of community organizations along this dichotomous thinking. This dichotomy suggests that community organizations adopt a single role as they navigate social and health policy. It also presumes that different roles in health and social policy are mutually exclusive. That is, producing expert knowledge subverts the production of local knowledge or that adopting evidence based strategies for policy development and service provision negates

adopting an activist stance. This depiction overlooks the possibility that community organizations adopt multiple strategies, relationships and forms of knowledge to impact health and social outcomes. Indeed, the case study depicted here shows that different roles and relationships are cultivated by home visitation providers as a strategy to cultivate their autonomy and influence in policy adoption and implementation. For instance, Families United actively works with and for state institutions and programs while they simultaneously operate to mobilize protest. They produce multiple representations of community needs and priorities in order to engage a wide range of actors in poverty governance. In doing so, the analysis reveals contradictions in neoliberalism, devolution and collaborative governance.

Place, Stigma and Health Inequalities

A large body of literature has shown that places contribute to the health and social wellbeing of their residents (Diez Roux and Mair 2010). Most work in this area details how material resources, economic configurations, environmental health risks, and racial segregation shape both individual and population health. However, and as cultural geographies and sociologists have noted, places are not only comprised of people and material conditions. They are also socially constructed to produce significant symbolic meanings among residents, the business community, outsiders, policy makers and health and social service providers (Bourdieu 1999; Gieryn 2000; Massey 1994). Because places are constructed out of social relations, they become geographic representations of social inequality (Bourdieu 1999).

Spatial stigma is a concept that conceptualizes the ways in which negative representations of marginalized communities contribute to the health of residents and the

social and health inequalities of populations (Bourdieu 1999; Wacquant 2007, 2008). The concept assumes that those who reside in or relocate from vilified and degraded areas embody the perceived negative characteristics of the environment. Marked by a stigma of place, this influences their sense of self, their daily experiences and their relations with outsiders (Keene and Padilla 2010). Outside of the individual, there is an extensive literature that connects stigma to the structural forces underling inequality (see e.g. Link and Phelan 2001, 2006). For example, the hyper segregation of African Americans in high poverty urban areas gives rise to areas that are symbolically degraded by racial and class stereotypes and through a lack of investment (Sampson 2009; Wacquant 2008). Segregated ghettos not only constrain economic opportunity, but they also become a form of symbolic oppression with the negative, cultural ostracism of African Americans (Geronimus and Thompson 2004). In a similar vein, Wacquant describes a “discourse of vilification” that proliferates around these areas creating a “blemish of place” (Wacquant 2007, 67) that is imposed on existing stigmas of poverty, race, and ethnic origin. Quantitative studies corroborate these qualitative findings. For example, Sampson and Raudenbush (2004) find that the relationship between objective measures and subjective perceptions of neighborhood disorder are moderated by the racial composition of an area in their study of Chicago neighborhoods. Neighborhoods that are predominately black are perceived to be more disorderly than equally disordered White neighborhoods. In short, these findings underline the point that places carry socially constructed reputations that are not purely descriptive of their material conditions. An emerging body of research identifies three mechanisms through which spatial stigma influences individual and population level health inequities: through access to resources that promote health and

protect against illness; through stress and coping processes and through processes relate to identity formation and identity management that influence health (Keene and Padilla 2010).

Building on prior research that demonstrates how the mechanisms described above influence health inequities, I add to the literature by examining how social institutions potentially mediate or reinforce spatial stigma in marginalized communities. Previous scholarship has focused primarily on analyzing how federal policies are paternalistic and some implementation studies highlight paternalistic micro interactions between case workers and clients. I contribute to this scholarship by adding a spatial dimension to the theoretical literature. By analyzing the practices of home visitors in varying community contexts, I am able to demonstrate how community agencies either disrupt or reproduce spatial stigma by their presence and intervention in the homes in both marginalized and socially desirable neighborhoods.

Autonomy, Home Visitation and Social Citizenship

As the previous section suggests, social service delivery is a key juncture in which the relationship between citizens and the state plays out. According to Michael Lipsky in his seminal work *Street Level Bureaucracy*, “In a sense, street-level bureaucrats implicitly mediate aspects of the constitutional relationship of citizens to the state. In short, they hold the keys to a dimension of citizenship” (Lipsky 1980, 4). Street level bureaucrats play a central role in determining the access that services users have to the status of citizenship and in turn, to their autonomy or psychological empowerment (Ben-Ishai 2012).

Autonomy refers to the capacity to live one’s life according to their own plans

(Ben-Ishai 2012). Given that humans are social beings, autonomy cannot be understood outside of interdependent, social relationships. Autonomy is an acquired set of capacities and a status that is acquired in the context of one's relationships to others (Anderson and Honneth 2005). As such, the capacities associated with autonomy "do not merely emerge naturally, but must be developed through various processes involving educational, social and personal resources" (Christman 2005, 87). Moreover, given the importance that liberal societies often place on protecting the vulnerable, institutions should be "concerned to address vulnerabilities of individuals regarding the development and maintenance of their autonomy" (Anderson and Honneth 2005, 129). For example, relationships of recognition are central to establish enabling relations to the self. When individuals are not recognized as legitimate citizens or are stigmatized on the basis of their gender, class, or race, their autonomy is threatened. In short, one's autonomy is vulnerable to disruptions in ones' relationship with others (Anderson and Honneth 2005). This vulnerability of our capacity to act autonomously brings into focus the power relations that are so crucial in determining what contexts will be most conducive to fostering autonomy.

Turning back to the crucial role of community agencies, service delivery is perhaps the key site of state-citizen relationships. For example, Joe Soss (1999) demonstrates that welfare participation teaches citizens how government and bureaucracy will respond to their claims and whether they have the capacity to act without fear of retribution. Through interviews and participant observation, Soss (2002) finds that the welfare state can be a key site for making claims that are effective in yielding tangible, immediate and helpful actions from government. Thus, even in the context of

mechanisms of social control, service delivery may afford recipients the opportunity for autonomy.

On the flip side, a number of scholars have argued and demonstrated that the relations of power involved in new paternalism is configured in such a way which suggests that the poor are specifically lacking in their capacity and autonomy to be productive citizens. Supervisory measures such as drug testing, behavioral modification interventions, and family caps work to “incite, reinforce, control, monitor, optimize and organize forces under it” (Smith 2007, 38). Rather than operate as an exclusionary force, paternalism is a more insidious form of power that is bent on subtle, generating forces rather than ones dedicated to impeding individuals by making them submit with coercive measures. Paternalist social service delivery does not use restrictions to control individuals; it employs techniques in a manner consistent with efforts to reform “the self.” As chapter 3 demonstrates, the rhetoric of home visitation appears to follow a paternalist logic by focusing on monitoring and scaffolding appropriate infant caregiver interactions, by using multiple screenings to diagnose and monitor the risk factors associated with poor parenting, and by employing a logic that assumes that the embodiment of poverty curtails parental abilities to successfully parent their kids. As a result, home visitation has become a key strategy to facilitate the reformation of the self through weekly home visits. A key contribution of this chapter is that it explores the extent to which this logic is implemented in the actual process of home visitation.

Methodological Approach

This chapter analyzes the extent to which the organizational practices and micro dynamics of home visitation follow a neoliberal, paternalistic logic by employing an

organizational ethnography of the state's largest home visitation provider, Families United. In the spirit of increasing calls to turn from macro to micro levels and to study actual mechanisms, the value of ethnography is critical to understanding the politics of home visitation and early childhood development. As Trickett and Oliveri argue "ethnography can capture the dynamic of change in ways that snapshot surveys using pre-established dimension and response categories cannot" (Trickett and Oliveri 1997, 149). Ethnography is advantageous to other forms of analysis for this particular research question(s) because it allows me to reconstruct how large scale social processes (the design of an early childhood policy agenda) actually occur in practice. The approach also illuminates how federal policy narratives constrain or even empower local actors in the daily governance of intervention practices (Schatz 2013).

The interpretive lens that I employ here draws out the social constructions of policy practices by considering how individuals create and act upon meanings about the causes and solutions for educational and health inequities among children. An interpretive approach is also useful because it relies on an epistemology that stresses the socially constructed nature of any claims to knowledge (Yanow 1996). In short, this inquiry is less about predicting or generalizing behavior and more about interpreting intention and meaning in context (Dodge, Ospina and Foldy 2005; Shank 2006).

The fieldwork for this chapter took place over a year and a half. During the process, I analyzed the agency's home visitation curriculum and key documents including strategic reports, policy briefs, and white papers. I participated in staff meetings; I conducted a staff focus group (N=3); I interviewed key leadership (N=3), I observed one-hour home visits (N=39), and I conducted a focus group with home visitation participants

(N=13). In sum, the fieldwork encompassed over 100 hours of direct observational work with the staff and families engaged with the program.

To investigate how Families United negotiates using evidenced based service provision while simultaneously using activist strategies to eliminate health and educational disparities that impact children, I interviewed staff members and I analyzed key agency documents and reports. After these interviews and document analysis were complete I coded themes from the interviews and used Atlas TI software to help establish patterns.

Phase 2, the most intensive part of the research, involved home observations of parents and home visitors. To recruit for home visitation observations, I was given a comprehensive list of home visitors to arrange visits. I contacted home visitors on a regular basis to schedule appointments with families that agreed to participate in the research.²⁰ In addition to ensuring that my observations included all home visitors, I also sampled for observations based on neighborhood conditions such as poverty and racial ethnic demographics.

A key advantage of the research design is that since Families United serves first time parents regardless of their income status and ethno-racial identification, the sample provides the variability necessary to analyze the extent to which home visitors enable parental capacity for autonomy or whether they engage in paternalistic practices. By including both low, middle, and high income groups and Latinos and Whites in the sample, I am able to compare how the dynamics of home visitation vary across these crucial dimensions of social stratification. This is important because explanations of

²⁰ It is important to note that my observational work was part of a broader study that analyzed the program's fidelity to their evidence-based curriculum. Given the administration's interest in evaluating their model fidelity, home visitors and clients were agreeable to my presence.

paternalism rest on the presumption that paternal social service delivery is rooted in a traditional conception of the father-child relationship and that poor people and racial and ethnic minorities lack the competence to manage their own affairs.

All home visits were conducted in English and to protect the anonymity of participants, I use pseudonyms to describe the key themes that emerged from my fieldwork. To collect the data for the analysis, I took extensive observational notes during scheduled home visits. This included documenting the home setting, the interactions between the home visitor and the family, and the substantive content covered during the home visit. I also coded the agency's home visitation curriculum by topic and counted the number and amount of time a particular topic was discussed. Examples of the topics covered include issues such as social and emotional development, feeding, sleeping, and attachment parenting. Finally, I generated a category that captured the amount of time spent discussing environmental conditions such as housing, joblessness and community safety. This coding allowed me to concretely measure and compare the time home visitors dedicated to cultivating parenting techniques versus the time spent on acknowledging and strategizing about environmental conditions. A typical home visit lasted 50 minutes. This ensured that the observations reflected the demographics of Families United's clientele. Since this chapter is interpretive, and the themes emerged from the data I did not impose a rigid, deductive coding scheme prior to the analysis. However, I do define paternalistic interactions as scenarios in which the home visitor dominated the discussion, when the home visitor ignored the client's concerns, and when the home visitor ignored cultural parenting practices. I used descriptive, values and attributional coding to analyze the home visit observations in order to generate key

themes related to the research questions.

The fieldwork for this chapter took place primarily in Bernalillo County, New Mexico. Similar to state level statistics, this county demonstrates disparities in school readiness and low graduation rates. For example, in Albuquerque, 64% of American Indians, 52% of Hispanics, and 51% of Blacks third graders scored below reading proficiency compared to only 31% of non-Hispanic white children in 2012 (NM Public Education Department 2012). The population of Bernalillo County is also unevenly distributed by race and ethnicity. Non-Hispanic Whites tend to be clustered near the University of New Mexico (UNM) and in the Northeast Heights district of Albuquerque. American Indians are greater in numbers in the far Southeast Heights, the “International District” (a neighborhood in the Southeast Heights of Albuquerque), and along the south and west borders of the county where the Isleta Pueblo, Laguna Pueblo, and To’hajiilee communities are located. Hispanics tend to be clustered in the South Valley and the West Mesa. The areas with the highest concentration of families below the FPL include the International District, the South Valley, and the West Mesa.

The home visitation observations took place in three primary neighborhoods in the Albuquerque metropolitan area. The first neighborhood, the Northeast Heights, is a suburban area that is primarily populated by upper to middle class Whites. Compared to other neighborhoods, crime rates are low and employment and high school attainment are high. In these neighborhoods, home visitors typically work with middle to upper middle class women who either elected to be stay at home mothers or were pursuing advanced level degrees. Participants in this area typically lived in middle class homes with manicured lawns, dedicated play rooms, and ample space for the family.

I also observed home visitations in two low-income neighborhoods in the Albuquerque metropolitan area that demonstrate significant disparities related to income, education and maternal risk factors. The South Valley is the site of the first originally settled area of Albuquerque, New Mexico. The predominantly working-class and Hispanic South Valley, home to approximately 32,000 people (five percent of the county population), displays high rates of unemployment and low education levels (fewer than 60 percent of adults over 25 have completed high school). Twenty-five percent of residents in the South Valley live in poverty and the area has the state's highest rates of teen pregnancy (Bernalillo County Place Matters, 2010). The South Valley's Hispanic community is divided between people who have lived in New Mexico for generations and new immigrants, approximately 15 percent of whom are not citizens, compared to statewide estimates of eight percent (Bernalillo County Place Matters, 2010).

Photograph 1: Life in the South Valley



Photo Courtesy of Ryan Rocco

The South Valley is a culturally vibrant community that includes urban and rural living. Some neighborhoods still have livestock in their backyards and other areas are more densely populated and contain newer suburban housing developments. The South Valley has been home to generations of Latino farmers and more recent Mexican immigrants who have faced contamination from heavy industrial development. In light of these economic and health disparities, South Valley residents continue to struggle with institutional racism and environmental burdens that include Mexican colonias with no governmental infrastructure and superfund sites.

The International District (ID) in southeast Albuquerque is a neighborhood with many negative social and health indicators. 20 percent of residents in the International District are enrolled in SNAP and less than 75% of them have a high school diploma (Bernalillo County Health Assessment 2014). In comparison to the rest of the county, the census tracts comprising the ID have a low median household income, low mean earnings, a high percentage of persons living under the poverty level, a high percentage of households receiving food stamps, and a low level of education attainment (U.S. Census Bureau 2012). The ID is densely populated, having one of the greatest densities of multi-unit dwellings in the city (U.S. Census Bureau 2012). It is also a relatively transient community—among the highest in the county for percent of persons with multiple residences in the last year (U.S. Census Bureau 2012).

The ID, pejoratively referred to as the war zone, is a highly marginalized area in Albuquerque. It is commonly stereotyped as a seedy area of town rife with drugs, prostitution, and neighborhood violence. While an active coalition of advocacy groups has worked diligently to promote economic development and to change the

neighborhoods' negative image, the ID remains an area with many challenges.

Photo 2: Urban Life in the International District



Photo Courtesy of Shannon Sanchez Youngman

I now turn to a presentation of the findings. I begin by exploring how Families United adopts multiple strategies to address the promotion of early childhood intervention policies statewide and I discuss their organizational structure.

Families' United Organizational Structure and Systems Advocacy Work

Families United remains at the epicenter of early childhood politics in New Mexico. While the organization is private, it has played a key role in advocating for increasing funds to support public early childhood policy interventions and it has advocated for the adoption of evidenced based models to provide effective home visitation. In the world of neoliberal deregulation, Families United represents how private, not for profit entities actively shape public policy through their influence in policy advocacy networks.

Families United is a private, faith-based organization that provides a blend of direct services and policy advocacy related to poverty reduction in New Mexico. This home visiting program serves first time mothers throughout the state. As one of the largest home visiting programs in the country, Families United provides home visits to over 600 families and employs 33 home visitors statewide. Unlike many home visitation programs that target their services to vulnerable populations, Families United is a universal, voluntary program. That is, it accepts first time parents regardless of their income, minority status or level of health risk.

Prior to engaging in policies and services aimed at improving early childhood outcomes, the organization had a long history of providing healthcare in New Mexico by financing several hospitals and initiatives related to health care delivery, especially among low income populations. Throughout its history, Families United has premised its activities on liberation theology. For this organization, it is through “fidelity to the gospel that urges individuals to emphasize human dignity and social justice to create healthier and more equitable communities” (Interview September 2016).

In the early 2000’s and after many years of financing hospitals, the organization’s board of directors made a drastic move to refocus their efforts to improve poor graduation rates in New Mexico. According to the agency director, Families United engaged in an intensive two-year strategic planning process to answer two questions: where could they achieve the greatest return for their investment and where could they create the most systemic change for healthy communities? In line with the ethos of evidence-based policy making described in chapter 3, their board met 26 times in one year with a professional facilitator. During the process, the board extensively reviewed research in

the field of infant mental health and child development. After months of intensive review, the board reached two conclusions. According to the agency Director:

We looked at the sign of the times, what is the need in New Mexico? So at first the thing that drew was the graduation rate and at that point, remember under Richardson (a former state Governor) it came out at 58%. So as we looked at this closer and closer, where the biggest return for investment was, and where the most systemic change could happen, it was in this population from prenatal to five years old. And I think one of the foundations of that information was James Heckman, and James Heckman's research showed the return of investment, that was important to us (Interview September 2015).

Based on what the administration touted as a "very systemic process," Families United selected three primary strategies to achieve their long term goal of increasing high school graduation rates and reducing socioeconomic disparities in New Mexico: policy advocacy, increasing the capacity of families to parent, through home visitation, and increasing the utilization of appropriate services through an enhanced referral program.

With respect to policy advocacy, Families United has become the champion of a large scale advocacy campaign to promote greater educational equity in New Mexico. Since 2010, the organization has supported efforts to use New Mexico's Land Grant Permanent School Fund to invest 1.5 percent of its \$15 billion to fully fund high quality early childhood programs.²¹ These programs include increasing access to child care among the poor, scaling up home visitation, and increasing access to pre-kindergarten education. In fact, Families United has refused to take public funds because in their view, retaining their private, organizational autonomy gives them more credibility to advocate for resource development for all early childhood programs (Interview September 2015). Blending the logic of the national early childhood policy movement, market principles,

²¹ New Mexico's Land Grant Permanent School Fund was established in 1910 to support public education. Unlike most endowment funds, it comes from two primary sources: royalties from oil and gas and earnings from investments.

and a social justice framework, Families United claims that these policy reforms are necessary to improve poverty rates and the wellbeing of New Mexican families.

For example, Families United explicitly uses evidence from neuroscience and the logic of the path dependency of early, adverse experiences to advocate for increasing funding streams to intervene in the lives of poor children. Congruent with national early childhood reformers, Families United suggests that the linchpin of successful poverty reduction is to take every step possible to fund interventions that remediate the behavior of poorly engaged parents. According to the agency Director:

So it's like these potters in New Mexico, they make some beautiful stuff and our children in New Mexico are like that clay with that pottery and those first three years are so crucial because you gotta get it while it's wet. And in New Mexico while that clay is still wet we poke holes in it with the adverse child experiences. Just that negative experience decreases or reverses the synapse growth. And then we take K through 12 investment and we want to pour it in there and everybody's screaming that it's not working. It's too late; you're on your way. So, if we can keep the pot without the damage of the adverse child experiences you know then they can hold it and then you're gonna have success and it changes their whole life, everything's different. And the home visiting eliminates a lot of those adverse child experiences (Interview September 2015).

By citing the work of early childhood policy entrepreneurs such as James Heckman and Jack Shonkoff, Families United clearly subscribes to policy development that rests on scientific rationale. Furthermore, congruent with private market principles and the logic of neoliberal poverty governance, Families United advocates for an amendment to the constitution that would give the legislature the authority to allocate early childhood intervention funds based on a competitive bidding system. That is, private non-profits would compete for contracted funds to provide direct services throughout the state. In a somewhat controversial manner, this proposal assumes that once funds are made available, the logic of competition will increase the quality of services offered throughout

the state. Moreover, rural areas with little infrastructure and community capacity will compete for services because “faith based and non-faith based organizations will pick up the slack” in areas where public systems are failing. (Interview September 2015)

Instrumental Social Justice

On the social justice front, Families United postulates that the promise of home visitation is that it reduces the isolation induced by poverty and the breakdown of familial support that once predominated traditional New Mexican communities. “You know we used to live in little tribes or haciendas, or whatever you want to call them, but we don’t, we don’t have that. The baby used to be exposed to 12 adults, now a baby’s exposed to maybe at best two” (Interview September 2015). For Families United, home visitation teaches individuals that “we’re not alone. Mama has a problem, it’s going to get solved, either by mama or somebody. That’s very community, that’s what the Pope is talking about--social friendship. That’s exactly it, you’re not alone” (Interview September 2015).

While acknowledging that structural inequities are induced by poverty and racism, this brand of social justice aims to build community by forming interpersonal relationships between home visitors and families. This philosophy is echoed by the program manager in her discussion of the effectiveness of home visitation as a poverty reduction strategy:

You are not a family member, but you sort of are because you start to know the family and you know the extended family. Like I’ve been out on the weekends and because of where they live and we live, I sometimes see their extended family members and they’ll come over and say, “Oh hi Deborah, how are you?” you know and it’s more of a friendship, it’s really becomes a friendship (Interview June 2015).

At the community level, Families United extends this logic by attempting to build community capacity by using networking strategies and by opening satellite home

visitation offices throughout the state. When the agency sees an unmet need in a rural county, they commonly open a satellite office and hire home visitors to deliver services in the area. According to an agency official, “the Gospel doesn’t call us to compete, it calls us to serve when there’s no one serving. ... So if we were able to help a community like Luna County get enough resources and get enough capacity to pull out, that they put us out of business, then that’s a success, that’s a success” (Interview September 2015).

Another layer of their diffusion efforts across New Mexico is to deploy home visitors to facilitate community building by actively participating in local community meetings and by joining local community boards. According to Families United, this form of organizing is very different than traditional grassroots social justice tactics. According to the management, Families United undertakes a subtler approach by “infiltrating” local service provider networks to induce support for early childhood policy interventions. Indeed, one of their key strategies is to directly finance several community-based initiatives and to share resources with local health and social service providers. For instance, the agency will provide one-time cash grants in increments ranging from \$50,000 to \$150,000. These financial gifts come with two expectations. First, they require that every funded agency agrees to publicly support the constitutional amendment to release the Permanent Land Grant Funds to early childhood education. And second, they ask that funded partners adopt evidence based social provision practices. In contrast to collective forms of organizing, this form of community action is premised on an underlying logic of exchanging goods to promote community health:

The public good that comes out of this is capacity for sharing information, for us making referrals out, them making referrals in and finding opportunities where they can either grow by, you know growth usually means money, or people coming into the organization. If you can help them with that, you’re on your way

you know. Though the problem in New Mexico is that we are really strapped and the only place to turn is the government because we don't have big corporations running big companies worried about their employees (Interview September 2015).

The evidence presented thus far suggests that Families United behaves in a manner typical of private organizations that seek to influence public policy. Families United supports policy reforms that are premised on market principles and they use their money to gain influence in rural communities. At least at the local level, Families United's brand of social justice is less about horizontally partnering with other organizations to mobilize and pursue broad, collective goals. Rather, their pattern is to galvanize autonomous community organizations to procure individual benefits through information sharing and individual social and financial support. As a result, Families United uses community building tactics that reveal a narrow, instrumental view of their community building work as they remain focused on providing resources to individuals and agencies who support their model.

Yet, the constellation of their advocacy efforts is not that simple. Families United has funded and partnered with statewide advocacy organizations to help create a statewide agenda to eradicate childhood poverty. Some of their efforts include the following. They have paid for knowledge campaigns that bring attention to the poor social and economic circumstances faced by rural and urban families, and they participated in statewide coalitions with other progressive advocacy groups to campaign for more public investment in childcare and early education. Most recently, Families United produced a bold public awareness campaign to raise awareness about deep seated poverty and educational inequalities in New Mexico. Through a multimedia campaign

launched in the spring of 2016, Families United mocked a recent multimillion dollar tourism campaign paid for by the state. Using parody, they reproduced the messages and visuals of a state tourism campaign by suggesting that the “land of enchantment” is not only a beautiful destination spot, but it ranks the worst in the country for child outcomes, its poverty rates are among the worst in the nation, and New Mexican children are hungry. This bold campaign not only drew widespread attention, but it was explicitly designed to be a conflictual organizing strategy with the intention of drawing attention to the state’s failure to invest in child care subsidies, early child education, and home visitation.

This analysis reveals that Families United undertakes a hybrid approach to community development. At the community level, the agency cultivates support for the diffusion of their home visitation model by negotiating relationships with other community based organizations through networking and knowledge sharing. Demonstrating a keen awareness of tensions and fractures in local politics, Families United exploits these ambiguities and lack of infrastructure to build networks that support their vision of home visitation. While the organization does not consider itself a competitor with other providers, it often behaves as a competitor for dwindling resources as it unapologetically promotes its specific model of care throughout the state. With respect to knowledge politics, Families United is preoccupied with best practice standards, technical expertise and accountability measures that may not fit local community needs in this vast rural state with many different sociopolitical dynamics. On the other hand, Families United has sought to encourage equity based policy reforms. Moreover, they have strategically used typical community organizing strategies as they

have targeted their grievances on key Republican legislators and state officials who have refused to implement wide scale policy reform on behalf of young children.

The Organization of Home Visiting Services at Families United

In addition to policy advocacy work, Families United has implemented a large scale home visitation program in several counties throughout the state. Key to this process was the selection of an evidence based home visitation curriculum developed by nurses and financed by Los Alamos National Labs. Less focused on clinical infant mental health intervention, the Families United home visitation model uses a skill based approach to facilitate infant social and emotional development. With a heavy educational focus, the curriculum is designed to teach mothers to cultivate their children's growth through activities such as reading, good nutrition, playing, and by promoting positive interactions between caregivers and their children. In effect, this intervention program seeks to cultivate parenting skills among mothers that mimic established patterns of middle class child rearing in the U.S (Lareau 2002).

Families United adopts a team based approach to working with families, but the agency is based on a strict organizational hierarchy with clearly defined roles and functions among frontline service workers. In Albuquerque, the agency's 26 home visitors are organized into quadrants that represent different neighborhoods that are stratified by race, class, ethnicity and population density. Clusters of para professional home visitors are supervised by team leaders who provide reflective supervision on a bi-weekly basis. Team leaders report to the program manager who oversees their work.

Home visitors provide the core link to families and they are the central node of communication with the family during their three-year intervention. On a weekly basis,

home visitors clad in bright blue polo shirts embossed with the agency's logo meet with mothers. When they greet families, they carry a tote bag full of toys and educational activities that are preplanned by the home visitor. Along with tips for feeding and reading, home visitors also use visits to conduct a vast array of the screenings described in chapter 3.

In a less central role, a nurse screens mothers for postpartum depression and health care needs during intake and at specified time periods during the intervention period. Enhanced referral specialists serve as care coordinators of sorts and their primary function is to quickly assist families with obtaining resources. When mothers express needs for housing, food and other assistance, the home visitor creates a task in an electronic record keeping system. Enhanced referral specialists who are assigned to geographic areas obtain the task and contact the client via phone. They undertake individual advocacy with families by enrolling them in social service benefits, assisting them with enrolling in childcare and by assisting with issues such as housing. Enhanced referral specialists serve as care coordinators and their primary function is to rapidly assist families with obtaining community resources by connecting them with referrals and by helping them navigate public and private agencies for things like food, diapers and health insurance. Enhanced Referral Specialists do not maintain a case load and by design, they are discouraged from forming meaningful relationships with families.

According to the program administrator:

Our referral specialists are really critical. They are amazing advocates both for individuals and families. Their job is to get in, get needs met and let the home visitor focus on what she needs to do. By design, I do not allow them to get too close to families. This creates a dependence that is never helpful over time. Families do need to learn independence (Interview March 2015).

This quote illustrates that while committed to improving the economic circumstances of their clients, Families United adheres to well documented neoliberal practices. The quote presumes that democratic citizens are individual consumers who should pursue goods, in this case referrals, from providers. The implication of her reference to the necessity of independence follows the neoliberal discourse that citizens are required to act as disciplined entrepreneurs. They must plan to meet their own needs, accept personal responsibility for their problems, and manage their daily affairs (Soss, Fording and Schram 2011). Performance concerns are also rooted in the work habits of Families United personnel. According to one Enhanced Referral Specialist:

We are like icing on the cake for home visitors. They go every week and form a bond with the mother, but we are here to help parents fill out applications and work with the system to get the benefits they need. We work behind the scenes to help families. It's pretty simple. When the visitor sees a need, they send us a task in the computer system and we follow up. We don't really see the family unless it's a big crisis. We work with the mom on the phone and when we are finished we move on to our next task. Our job is not to form a deep connection to families—that's what home visitors do (Interview October 2014).

As this quote illuminates, Enhanced Referral Specialists expect to be held accountable for the outcomes they produce, they are quick to complete tasks, and they express a commitment to improve performance through evidence-based methods of practice. Families United expresses a commitment to remediating the ills of poverty by supplementing home visits with this referral mechanism. Indeed, clients report that referral specialists have been instrumental in helping them enroll in programs like Medicaid and food stamps. Yet, by structuring poverty advocacy around service referrals, Families United locates the problems of poverty and poor living conditions within the individual rather than implementing strategies that bolster community development.

Moreover, and congruent with new performance management, home visitors, nurses and enhanced referral specialists maintain very separate functions with little integration of their efforts within the agency. For example, the organization strictly forbids team meetings about families and all communication regarding a given family is relayed through an electronic record keeping system. This organizational practice potentially limits the frontline staff from assembling a more holistic picture of the family with a deeper sense of the contextual factors that impact their home environment and their ability to parent effectively. This organizational design obscures the political dimensions of social problems by relegating them to a matter of choice. According to Wendy Brown (2003), “the causal story of a ‘mismanaged life’ becomes a new mode of depoliticizing social and economic powers.”

Observational Analysis

I now turn to an analysis of 32 home visit observations. I examine whether home visitation enables autonomy among home visitation participants and the extent to which Families United conforms to a paternalistic logic of service delivery. To begin the analysis, I describe the racial and class characteristics of the families observed in the study. As Table 6 indicates, the majority or 64 percent of home visitation participants were Latino, 26 percent were non-Latino white, and 5 percent were Black and Native American. With respect to class, 31 percent of the observations took place in poor households, 38 percent of the observations included working class families, and 31 percent occurred in middle class families. As these descriptive statistics demonstrate, the

observations encompassed a wide range of families with different social, cultural and economic circumstances.

Table 6: Ethnoracial and Class Characteristics of Home Visitation Participants

Class	Non-Hispanic White	Hispanic	Black	Native American
Poor^a	5.13% (2)	20.51% (8)	5.13% (2)	-
Working Class^b	5.13% (2)	28.21% (11)	-	5.13% (2)
Middle Class^c	15.38% (6)	15.38% (6)	-	-

N=30

Notes:

^a Poor families are those who live in households in which parents receive public assistance and do not participate in the labor force on a regular basis.

^b Working class families are those who live in households in which neither parent is employed in a middle class position that entails substantial managerial authority and that does not require complex educational certified skills. It includes lower level white collar workers as well.

^c Middle class families are those who live in households in which at least one parent is employed in a position that either entails substantial managerial authority or that draws on highly complex, educational skills.

In addition, and as Table 7 describes, about half of the families lived in houses while the other half lived in either apartments or trailers. Somewhat surprisingly, mothers were consistently present for home visits, but in approximately half of the observations either the father or extended family members were present with the mother. While not shown in Table 7, the presence of extended family members and fathers was most common among Latino working class and poor families.

Table 7: Characteristics Caregivers and Type of Dwelling Unit

Type of Residence	Percentage	Caregivers Present During Visit	Percentage
Apartment	38.46% (15)	Mother	48.72% (19)
House	51.28% (20)	Mother and Father	25.64% (10)
Mobile Home	10.26% (4)	Mother and Extended Family	25.64% (10)
	n=39		n=39

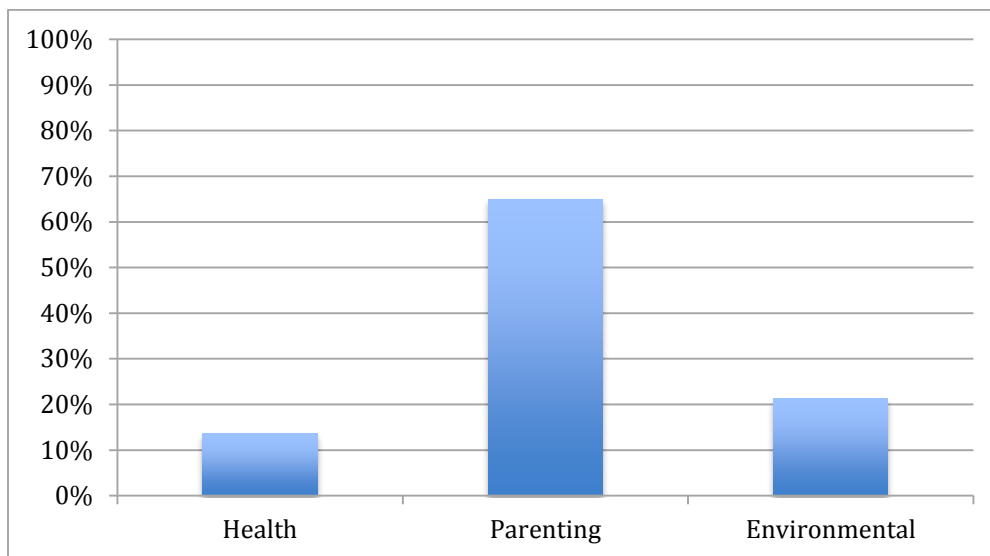
This descriptive finding may be due to Hispanic cultural practices of childrearing which entail maintaining strong family ties and raising children closely with their cousins, aunties and grandmothers always nearby. The fathers that were present were typically younger and working class. These fathers were very engaged in home visits and appeared to invest heavily in child rearing practices. This finding contradicts the evidence that wealthier and higher educated parents dedicate more time to their children than non-college educated ones (Bianchi et al. 2004; Esping-Andersen 2009, 72; Hook and Wolfe 2011).

I now turn to a discussion of the time use data collected for the study. The time use data overwhelmingly suggests that home visitors spend a very small proportion of their time discussing the environmental concerns raised by mothers and fathers. As Figure 8 demonstrates, the vast majority of the discussion focuses on parenting topics ranging from sleeping routines to infant massage.

Enhanced Referral Specialists were only mentioned three times by home visitors. When environmental concerns were raised by parents, there were only six referrals made to connect families with Enhanced Referral Specialists. Perhaps most critically, home visitors rarely brought up issues related to family's social and economic circumstances. When families attempted to make meaning of how their environmental conditions

impacted their parenting, home visitors tended to deflect these conversations. Instead, they used multiple strategies to redirect the parent back to the discussion related to the educational curriculum. By silencing their grievances, home visitors indirectly implied that parental behaviors were the most important contributors to their children's health.

Figure 8: Time Spent on Health, Parenting, and Environmental Conditions in Home Visitation



N=1,889 Minutes

Home visitors led the conversation by planning each home visit prior to meeting with the family. In a didactic fashion, the home visitor brought a topic of her choice from the curriculum guide and structured the visit around a pre-established educational directive. While this top down approach provided a structured visit, the evidence suggests that it also stifled the voice and needs of parents who expressed concerns and desires that diverged from the structured discussion. In the next part of the discussion of the results, I offer a series of vignettes to illustrate the key themes that emerged from the analysis.

Deflecting Environmental Concerns and Constructing the Good Mother

The first vignette represents a home visit that took place in the International District in Albuquerque. The young, immigrant mother, Teresa, greeted her home visitor,

Maria, in front of her old apartment complex. Teresa was the mother of a 10-month old daughter, Fatima. She also had an older son and was married. The complex was built in an adobe style of architecture and contained barred windows, a communal patio area with dirt, and a fence that surrounded the perimeter of the building which contained six apartment units. The apartment was approximately 700 square feet with a small living room opening to a kitchen with two bedrooms and a bathroom to the right of the family area.

Photo 3: A Typical Apartment Complex in the International District



Photo Courtesy of Shannon Sanchez-Youngman

The apartment was spotless and the walls were adorned with crosses and pictures of Catholic saints. The furniture was covered in plastic and it was clear that Teresa enjoyed decorating and cleaning her home. Moving through a small hallway with an exposed water heater, we entered a small bedroom that contained a twin size bed, a desk, and a play area for Fatima. The play area contained toys and a play mat made of colorful, rubber tiles. Teresa placed Fatima on the floor and tried her best to keep her on the rubber tiles, so that “she could stay clean.”

Teresa had been seeing Maria since her pregnancy. She was clearly excited to talk with Maria and she spent some time describing her week and sharing new milestones about Fatima. Teresa expressed some concerns about Fatima's propensity to cry more often than usual and wondered if this was normal. Maria listened carefully to Teresa's concerns and assured her that crying is normal and expected in infants. To quell her worries, Maria asked if Teresa noticed any new behaviors in Fatima or if there was a significant change in Fatima's routine. Teresa noted that Fatima was chewing on her fingers a lot and maybe she was teething. Maria reinforced Teresa's observation and suggested that teething may be the culprit for her recent crying spells. Maria offered some suggestions to make Fatima more comfortable and they continued on with the educational topic for the day.

Moving forward, Maria reached into her black bag and pulled out worksheets that included checklists for improving child safety. Maria began the conversation by asking if Teresa was able to review the home safety checklist from their previous visit.

Maria: Teresa, I want to talk about home safety. Did you read the handout from last week?

Teresa: I read all this stuff and I have covers on the outlets but I don't know what to do. The water heater is exposed and she can burn herself...I don't know. This landlord won't do anything. I have cockroaches the detector does not work. Five babies live in this complex and its not safe here. I do my best, but its hard to keep her safe here. Is there something we can do to get the landlord to fix these things? I've tried to tell him and he ignores me...

Maria: You are right building codes are important. Its not right. Hey, were you able to get those free diapers from the shelter?

After this short and somewhat tense discussion, Teresa responded to Maria's question and noted that the shelter that she obtained the diapers from was "creepy." Teresa said that manager was unfriendly and harsh when she asked for diapers. Maria agreed and said that this shelter serves homeless people with a lot "drug problems." She reinforced

Maria's observations and concluded the discussion by noting that she understood that it was "hard for a good mother like Maria to go to these places to get diapers because these shelters are full of people that have drug problems and criminal backgrounds," but that they were one of the only places to get diapers.

As the description illuminates, home visitors use several strategies that potentially foster autonomy among vulnerable mothers. In this case, it was clear that Maria and Teresa had secured a trusting, mutual relationship. Teresa was willing to share private information with her home visitor and Maria honored Teresa's knowledge about her child. She supported Teresa's hunch that Fatima's recent tantrums were related to teething. Similar to other examples, this approach created a mutual dialogue between the home visitor and the mother. By acknowledging the mothers' intuition, the home visitor reinforced the parent's capacity to make good parenting decisions on behalf of her infant.

On the other hand, the home visitor failed to completely implement a "democratic politics of care" when she ignored the mothers' concern for her environmental safety. A more enabling process would have included a discussion in which the mother could define her needs more fully. The pair could have then worked together to determine the appropriate arrangements to meet her concerns related to poor housing conditions. Indeed, it was surprising that the visitor did not mention that the enhanced referral specialist could help her write a letter to the local tenant association to advocate for the landlord to comply with basic housing codes.

By ignoring Teresa's interpretation of her safety, Maria implied that Teresa's conditions were normal in this part of town. She attempted to remediate the situation by positioning Teresa as a good mother in comparison to the "undeserving poor" that hung

out at the shelter, but her comment revealed something more insidious. It suggested that while Teresa thought she had it bad, she was better off compared to the hyper marginalized residents of the International District.

Home visitors also skirted these issues with families because they were fixated on delivering the manualized curriculum. As the organizational analysis points out, home visitors are incentivized to deliver education and to conduct screenings because this is how their performance is evaluated. This pattern reveals a central paradox in evidence based home visitation models. By fixating so heavily on promoting skill-based parenting practices, the evidence based model misses the opportunity for home visitors to enter into the lived experiences of families to facilitate a dialogue that potentially increases peoples perceived control of their lives as an empowering agent, the home visitor could have harnessed Teresa's critical awareness of her social context to take concrete actions that would remedy perception of real or perceived powerlessness that emanates from the injuries of poverty, insufficient resources, and social isolation.

Ignoring Social and Economic Circumstances and the Dance of Expert Verses Lay Knowledge

In the second vignette, I visited the near South Valley on a Thursday evening. I drove to a Hispanic barrio that contains a combination of small casitas densely grouped together along several blocks that are filled with lots of outdoor activity. Neighbors regularly eat and drink together in the front yard, they commonly light bonfires and share memories, and their children play freely outside. Just five blocks away, there is an older industrial area that contains old tire shops, abandoned buildings, and some small scale production facilities. The area is quiet and looks somewhat deserted.

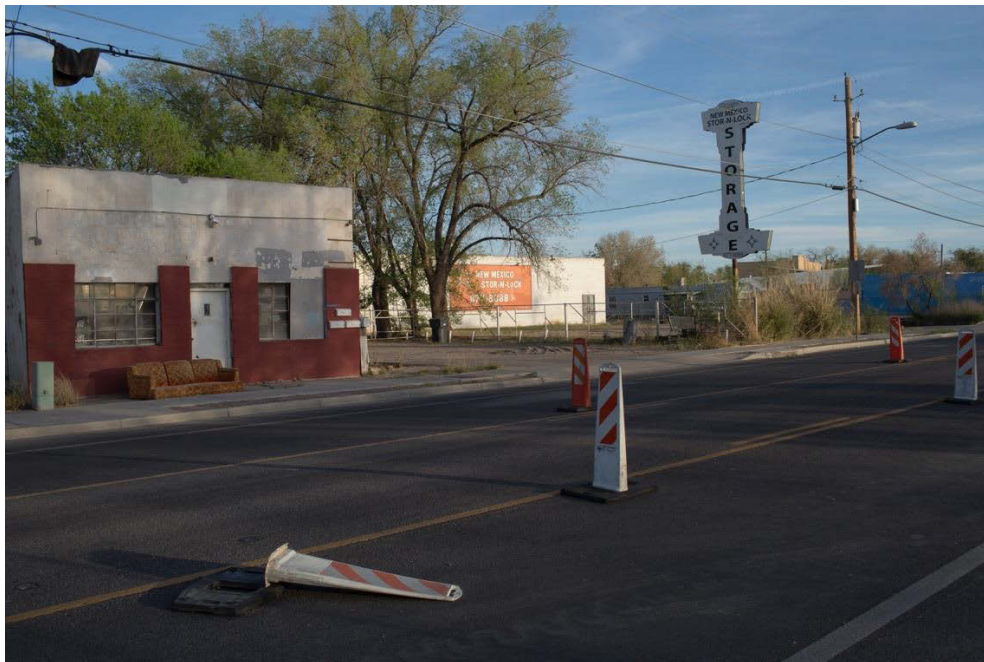
Photo 4: Industrial Zoning and Housing in the South Valley

Photo Courtesy of Ryan Rocco

I pulled into a large dirt parking lot that was surrounded by casitas that were subdivided into efficiency apartments. The home visitor, Susie, was greeted by a large immigrant family who left the apartment so that Susie had the space to meet with their daughter, Armada, her 10-month old son, Mateo, and his father, Jacob. The apartment was tiny. It contained a room with a full size bed and small desk, a small kitchen to the right and another door that led to a bathroom and small, makeshift bedroom. Seven people lived in the place. Susie and Armada sat on the bed, Jacob sat on the floor, and I sat on small desk chair next to the bed.

Susie was an approachable home visitor who used hands on techniques and modeling to deliver the content of her educational intervention. On this particular visit, she brought Mateo a board book and sat and read with him while she engaged in casual

conversation with the teen parents. She asked Armada about her progress in school and supported Armada's decision to pursue an associate's degree in early child care at the local community college after she completed high school in the Spring. Jacob discussed his frustration with finding a job, but he was continuing to look for something. As Susie casually read and spoke to the parents, she also raised the topic of co-sleeping with the teen parents.

Susie: So is Jacob sleeping with you guys?

Armada: Yes.

Susie: You know research says that co-sleeping is dangerous and you both have told me that Mateo sleeps hard. I will refer you to the specialist who can help you with a crib.

After an awkward silence, Armada noted that she was unsure if she had space for the crib and it may be better to wait until she and Jacob could afford their own apartment. Susie continued to read to the child, and showed the parents some games to encourage Mateo to reach and grasp for objects. She returned to the discussion of co-sleeping as the visit was coming to an end.

Susie: I just want to talk about sleeping again. There are pros and cons to co-sleeping and this program no longer supports sleeping safely in the bed. Research shows that parents can smother the baby in their sleep.

Jacob: (with a chuckle, holding Mateo who is asleep on his chest) Well sometimes he sleeps on my chest.... just like this.

Examples like these present clear evidence of how home visitors engage in paternal practices. In this case, it was obvious that the family was unable to place a crib in such cramped living conditions. Co-sleeping appeared to be their choice and these teen parents lacked the resources necessary to accommodate the home visitors concerns. What's more, the home visitor failed to acknowledge that four other people lived in such a cramped space.

This vignette represents a common pattern revealed in the study. Home visitors had a tendency to rely on evidence based practices to reinforce authority based relationships with program participants. As I described earlier, this kind of dynamic reproduces unequal status and power between service providers and members of the community. In this case, the home visitor wielded her research based authority to warn the parents that they could induce harm on their young child if they did not comply with best practices. Moreover, and similar to the previous example, the home visitor relied on a narrow, middle class conception of “infant safety” to make her point clear. In the process, she completely negated alternative positions and research findings on co-sleeping. Through her insistence that co-sleeping was unsafe and that her agency had the resources to quickly solve the problem by obtaining a crib, the home visitor indirectly stigmatized their dependency on public assistance to make ends meet. Rather than brainstorming with the parents about their expressed aspirations and need for gainful employment, the home visitor implied that in order to be a good, deserving mother, the client should first meet the basic criteria of making her baby safe. In a subtle way, she responded to the supposed incompetence of these parents by making her services and continued guidance conditional on the parent’s conformity to evidence based behavioral requirements.

This interaction also illuminates common forms of resistance to paternalist tactics. In this case, the father indirectly resisted her knowledge claims by re-claiming the reality of his child’s sense of safety while the baby slept quietly on his chest. This point reinforces the idea that families do retain a sense of agency even when home visitors suggest that they lack the competency to manage their own affairs. The danger here is

that frontline bureaucrats can replicate relations of power that are themselves implicated in the structural causes of social stratification.

Stigmatizing Class Differences in Parenting

The third vignette took place in the International District in a working class neighborhood. The family lived in a small apartment in an old complex with barred windows and doors. The apartment contained a small living room, dining room and kitchen with two bedrooms in the back. A large screen television was on during the discussion. The Hispanic mother, Chastity, was in her early twenties and her Hispanic husband, Ernest, was slightly older. Their son, Joaquin was just over two years old.

Chastity was incarcerated for a parole violation a few days prior to the visit and faced jail time because her parole officer found alcohol in the house. Chastity and Ernest also had an older daughter who was staying with Chastity's mother as a result of her recent arrest. Her older daughter had been previously taken under state custody when Chastity served time for a drug offense. During the visit, both parents were very worried about a new child abuse investigation. Chastity had been clean for several years and she explained that her brother brought the alcohol over during a recent family gathering to watch a boxing fight.

In spite of the impending crisis, Stephanie, a relatively new home visitor, chose to move quickly into the curriculum topics for the day. Despite her anxiety, Chastity participated in the visit with enthusiasm. When Stephanie delivered the results from Joaquin's latest Ages and Stages Developmental questionnaire, Stephanie retrieved a binder filled with all of her home visitation activities and screenings to insert Joaquin's results. As Chastity and Stephanie reviewed Joaquin's developmental milestones, Ernest

listened and chimed in when he felt it was appropriate. With the situation obviously weighing heavily in Chastity's mind, she occasionally looked to Stephanie for guidance and reassurance. Chastity wondered if she would go to jail, she asked how the program could help her, and she expressed how hard she had worked to "get her life together."

Each time she posed a question or inserted a concern, Stephanie had difficulty responding to Chastity's situation. She responded by saying things such as, "yes, this sounds stressful," but she never directly confronted the crisis. When Chastity raised her fears, Stephanie quietly returned to the screening. Near the end of the visit, Stephanie and Chastity began to discuss her reading routine with Joaquin when the phone rang. Chastity anxiously stood up, announced it was her parole officer, and went outside.

Chastity: Oh my god. It's my parole officer. I have to take this call.

After an awkward silence, Ernest moved onto the floor with Joaquin to continue the discussion.

Stephanie: Do you read to your son?

Ernest paused, looked down and blushed. In a small voice he muttered the following.

Ernest: I can't read, but I try to watch television with him and take him to the park.

After some consideration, Stephanie cautiously responded.

Stephanie: Well, you can read with pictures. This is good bonding time with him.

Just after the discussion, Joaquin crawled away, Ernest ignored Stephanie's response, and he disciplined the child by yelling at him for getting too close to a bucket sitting in the dining room.

This vignette illustrates a typical interaction between a home visitor and what the staff call "hard to serve" families or "chaotic clients." As evidenced in the vignette, these clients tend to experience drug abuse, domestic violence, and child abuse and neglect. Consequently, these mothers are typically engaged with a number of public and private

agencies in the social, health and legal domain. As is often the case in these crisis situations, the home visitor was unsure of how to handle the situation. When we debriefed after the visit, she expressed her concern for the family but noted that it was not her responsibility to help her navigate the situation. In her view, the mother was connected to other resources.

This example provides further evidence that Families United tends to ignore family's social, economic, and in this case, legal circumstances. It also illuminates a deeper, structural issue. It exemplifies how a devolved and fragmented system of care was failing this mother. Put simply, the home visitor fell back on her narrow script as a parent educator and eluded any responsibility to help advocate on behalf of Stephanie and her children. When Chastity scheduled her next weekly visit, Chastity teared up and said, "I hope I will be here for it." Stephanie smiled and responded, "Until next time, good luck."

Stephanie did not question the veracity of Chastity's claims, but like many other service providers existing in a world of fragmented governance, Stephanie quietly opted out of the crisis. In a way, it is unrealistic to expect a home visitor to address every need raised by a family undergoing difficult circumstances. Yet, as the state increasingly relies on market actors to achieve public purposes, there are no institutional mechanisms in place to ensure that private and community based organizations will cooperate as co-participants deliberating and acting together to improve. (Crenson and Ginsberg 2002).

Conversely, women like Stephanie will pursue better outcomes from other providers (exit) rather than wasting precious time engaged with providers who are unresponsive to their needs (voice). This highlights a fundamental problem with ceding

public control of social services to private, community based agencies. The democratic link between citizens and government is severed because private organizations are unaccountable to public scrutiny.

Aside from these structural limitations, this example highlights how home visitors often infantilize poor fathers during visits. In the example presented here, the home visitor paid little attention to the father's extreme discomfort with his illiteracy. She quickly retorted that he could read with pictures in a manner that was demeaning. The home visitor did not offer any support in response to his visible shame and embarrassment. In this interaction, there was a fundamental disconnect between a recognition of his circumstance and the program's goals to support reading strategies to develop cognitive and language capacities in young children. Like other paternalist interventions, the underlying assumption is that early childhood interventions hold the promise of producing healthy citizens in spite of the deep seated problems exemplified by their parents.

This vignette also points to a broader finding. Home visitors typically infantilized poor and working class fathers, missing a crucial opportunity to support and acknowledge the importance of participating in their children's lives. In contrast, home visitors tended to reinforce traditional gender roles in middle class families and they praised fathers who provided material resources for their kids. For example, during a middle class home visit in the Northeast Heights the home visitor suggested that it was mothers' responsibility to meet her husband's needs.

Home Visitor to a white, middle class mother: I know that raising the baby is tough, but are you making time for your husband?

Mother: Yes, I try.

Home Visitor turns to the infant and says the following.

Home Visitor: I'm going to give your mama a handout that gives her tips on how to make time for daddy. Their relationship is important too!

Interactions like these reflect the organization's support for a family values agenda in which marriage is seen as an institution that is capable of redressing many social ills. In line with social conservatives, this faith-based organization promotes father involvement as a core component of healthy child development. Marriage is lauded as a bulwark of social order and virtue upon which successful citizenship rests.

In contrast, home visitors were systematically less concerned about how poor and working class fathers spent their leisure time with their children. Instead, their efforts were directed at teaching fathers about very basic parental concepts. According to one home visitor:

Fathers and mothers can be really different with kids. Sometimes fathers are rough. You need to make sure you hold the baby's head gently. Think of his head as a tennis ball. If we put the tennis ball in a shoebox it just rolls around.

The presumption here is that poor and working class fathers lack the capacity to perform basic parental tasks. This example dovetails with other scholarship which suggests that the lens of moral behaviorism and the shared "ethnoracial" bias embedded in the routine operations of U.S social welfare institutions splinters citizenship along class lines (Wacquant 2008, 2010).

Indeed, other examples reveal clear differences in how home visitors interacted with middle class families in comparison to working class and poor program participants. When home visitors visited with middle class mothers, they produced elaborate, homemade cookbooks filled with recipes for healthy toddler snacks like baked kale, they actively acknowledged that "highly educated parents like you understand what I mean," and they refrained from using top down methods to discuss parenting practices. As

Bourdieu cogently argues, practices like these arbitrarily reward the cultural parenting practices of the middle class because of the close compatibility between the standards of child rearing in privileged homes and the (arbitrary) standards proposed by institutions (Bourdieu 1986). Moreover, this division corresponds to theories that link the bifurcation of social service beneficiaries to contrasts between the “deserving and undeserving.” In turn, these stark divisions reflect the tendency of social welfare institutions to reinforce oppressive systems based on gender, class, and racialized ethnicities (Mink 1998; Orloff 1996; Quandango 1994; Weir, Orloff, and Skocpol 1988).

The Dominance of Western Parenting Practices

In the final vignette, I illustrate how an intense preoccupation with the connection between neuroscience, parenting, and infant development clashed with other, alternative ways of knowing. This home visit took place in a duplex in the university area in a middle class neighborhood that contains a mix of business and medical professionals, university academics, and both graduate and undergraduate university students. The visit occurred on a Friday evening with a Navajo family. The mother, Mona, was finishing her undergraduate degree in biology and was in her mid-twenties. Her son, Boyd, was just three months old and the walls were adorned with a “Welcome Home” sign and pictures of her family and the baby. Mona’s parents, Joe and Frances as well as her sister, Lorraine, were present for the visit. When Susie entered the house, there was a great deal of activity. Frances and Lorraine were unpacking groceries and starting dinner, Joe was holding Boyd, and Mona was organizing some paperwork at the table. Mona introduced all of us to the family and I explained my role to Joe who wanted to understand more fully why I was there.

Susie wanted to use this visit to complete Boyd's first developmental screening and to educate the family about the benefits of using techniques like eye gazing, talking and holding Boyd to promote his brain development. Mona and Susie sat on the floor together on a blanket with Boyd laying in the middle. As Susie went over the questionnaire with Mona, Joe frequently added his perspective to the conversation.

Susie: You see how he's making these cooing noises? These are his first attempts to develop language. It's important for you to continue to talk to him so that his brain continues to develop the neural connections to speak and think well.

As Mona nodded her head with a smile, Joe interrupted Susie by reaching down and taking the baby. Susie looked up and continued to talk about other strategies to stimulate brain development with Mona. Joe interrupted the conversation by loudly singing in Navajo to Boyd. After several minutes of singing, Joe paused and looked directly at Susie and chuckled.

Joe: When we have a baby we create their song. This is Joe's song.

Susie: (Enthusiastically) Wow! That was incredible. Just like I was saying, when we sing to babies we help their mind develop!

As Susie returned to the developmental screening with Mona, Joe took his coat and announced that he would be back later.

The vignette presented here illustrates a struggle. In this case, Joe was actively resisting Susie's interpretation of the nature and process of child development. His reaction did not necessarily imply that her interpretation was wrong, but his actions suggested that she was ignorant of his family's cultural context.²² In her discussion of neurological development, Susie drew upon a universal logic of scientific rationality and individualistic assumptions about health promotion and prevention (e.g.—see Dutta 2007,

²² I conceptualize culture as a complex and dynamic web of meanings that is in flux as it interacts with the structural processes that surround the culture (Dutta 2008). (Airhihenbuwa 1995). Culture is articulated in the meanings co-constructed by participants and the meanings are located within the local context of culture (Dutta 2007).

2008). Joe, on other hand, presented an alternative story that was rooted in local indigenous knowledge and child rearing practices. Susie's response to Joe's song was telling. When she declared that singing was a good strategy to develop the baby's cognitive skills, she silenced his voice. In effect, her actions subordinated his knowledge within socially authorized forms of public discourse. Without reducing the scenario to a simplistic "clash of cultures," examples like these highlight how service provision is a critical site where individuals and street level bureaucrats struggle over the interpretation of need, the power to define it, and the authority to determine what would satisfy it (Fraser and Gordon 1994). By failing to take into account the perspective and needs of those whose needs are at stake, this exclusion is rooted in a paternal philosophy which presumes that those in need of home visitation must be lacking in autonomy.

Conclusion

The community building and social service delivery practices of Families United reveal multiple layers of contradictions. On the one hand, Families United maintains a firm commitment to advocating for progressive social policy change. They have embarked on public awareness campaigns and coalitional politics that are aimed at eradicating child poverty and poor educational and health outcomes in the state. The agency has engaged in confrontational politics to openly challenge conservative opponents who have disinvested in social service and health interventions in this small state. On the other hand, Families United conforms to both paternalistic and neoliberal practices.

The observational analysis presented here contains many implications. Home visitors' strict adherence to the curriculum and their tendency to focus on building "social

friendships” with families had the effect of completely decontextualizing the intervention from the lived experiences of vulnerable families. Especially among poor and working class families, home visitors tended to ignore their living and neighborhood conditions, their personal support networks, and their legal status. As home visitors spoke with mothers about caring for their children, the link between the built environment, social structure, and the collective psychology of vulnerable families slowly receded into the background as home visitors proselytized about the virtues of parental attachment and cultivating skill development among their children. In an almost absurd way, the practice of home visitation entailed a process of retreating into the private sphere, leaving behind contextual conditions faced by families. This contributed to the spatial stigma experienced by families living in marginalized areas. In this way, the analysis presented here represents the manifestation of the politics of intimacy described in chapter 2. Home visiting practices reinforced the idea that self-realization is at the center of healthy development. They buttressed the notion that it is primarily the parent’s responsibility to cultivate healthy attachments with their infants in order to break the cycle of poverty. While it is perfectly reasonable and intuitive to suggest that holding your baby and reading to him or her is beneficial, the shortcoming described here is that Families United conveys these messages through practices that potentially disempower families. Indeed, and this chapter demonstrates, private community organizations are themselves conditioned by acceptable practices sanctioned by their larger community of practice.

The paternalistic practices uncovered here could be interpreted as a function of the racist and classist attitudes of individual home visitors. This is simply not the case. Home visitors are organizational actors. As they carry out their transformative moral

work with clients their efforts are structured by the tools, cultures and routines supplied by their organizations. Consequently, much of their behavior can be explained by their organizational position (Lipsky 1980). In this case, home visitors were conditioned by the performance measures and evaluation standards created by Families United. As the organizational analysis shows, Families United is a hierarchical organization with an impressive surveillance system of frontline service workers. This system entails a sophisticated electronic record keeping system replete with checklists, task reminders, and a space dedicated to the documentation of the curriculum covered during the home visit. What's more, Families United imposed a top down management structure with strict guidelines imposed on frontline staff members.

While the picture painted here looks dismal, there is potential for agencies like Families United to undertake a more empowering approach with families. In an important turn of events, Families United demonstrated enormous flexibility to alter their practices by virtue of being a private provider. Indeed, when I presented some of the initial findings to the agency as part of a larger fidelity project, the agency leadership was open to feedback. They were especially concerned about the disjoint between enhanced referral specialists and home visitors. The program manager was alarmed to learn that home visitors made few referrals to the care coordinator, especially when the apparent need was so high. Even more importantly, since the study period ended, the agency has revised their service delivery model veering away from their original curriculum and has implemented new materials that are explicitly designed to help families navigate poverty, joblessness and other social issues.

Chapter 5: Conclusion

It has been twenty years since critics and pundits have declared that the U.S. social welfare state has entered into a new era of neoliberal-paternalist approaches to poverty governance. Beginning with this theoretically rich, empirically validated, and pessimistic portrayal of U.S. social policy, this dissertation began with a puzzle. I wondered why, in spite of this compelling scholarship, states were beginning to rescind some of these punitive welfare measures and why federal, state and local service providers became so fixated on the promise of early childhood policies to become the new progressive solution to mitigate the ills of poverty on the life chances of children in the U.S. At first glance, it appeared that progressive social advocates had successfully exploited the deregulated policy environment to pass and implement new health and social poverty reduction strategies that could make real headway in improving lifelong health and in improving health and social inequalities.

Yet, the story presented here paints a decidedly more tempered portrayal of contemporary efforts to roll back punitive measures and to improve the circumstances of poor women and their children. Indeed, one key finding related to the repeal of punitive social policies is that efforts to rescind these measures not only represented the counter mobilization efforts of liberals and Democrats, but they were also a story about emergent rifts between social and fiscal conservatives. At the height of welfare reform, social and fiscal conservatives remained united in their commitment to roll back the welfare state and to hold the poor more “accountable” for their perceived failings. But in an era of evidence-based policy making, social conservatives learned quickly that their initial support for family caps could potentially lead to an increase in public abortion rates

among the poor. This not only challenged the moral politics of groups like evangelicals, but these welfare policies could potentially work against their statewide efforts to impose tougher regulations on abortion providers. In effect, social conservatives learned that the costs associated with family caps outweighed the benefits of decreasing out-of-wedlock births.

Political conflicts over social and health policy are also increasingly waged using data and scientific, “expert” knowledge to lobby for reforms at the federal, state, and local level. Political struggles to adopt and implement family caps were waged along these lines. The interesting point about these struggles is that they potentially obfuscate the underlying ideological struggles among political actors. In this way, the politics of social policy is increasingly hidden from public view and political actors on the left and right increasingly use regulatory tactics to incrementally support their wider political agenda.

In line with the constructivist institutionalist framework that I lay out in chapter 2, both the development of early childhood policy and the trajectory of family caps over time reveal how a series of low-profile policy processes continued to slowly transform the nature of the country’s welfare regime outside of critical junctures and exogenous shocks (Hacker 2004). To borrow Thelen’s (2004) much cited term “layering,” the analysis presented here demonstrates how health and social service interventionists grafted new elements onto an otherwise stable, yet diffuse institutional setting to achieve their goal of implementing evidence based home visitation practices throughout the country. As a result of this process, the infant mental health movement slowly gained the

authority necessary to adopt new approaches that used clinical and skill based methods to monitor the individual behaviors of poor women.

A key contribution of this study has been to articulate that in order to understand the politics of institutional change and the factors that explain the direction of these incremental changes, however, one must recognize the control role of ideational processes in politics and policy making. As chapter 3 elucidates, the institutional development of home visitation intervention policies were contingent upon the effect of this policy network's ideas and assumptions about poverty as a risk factor; their medicalized approach to parenting deficiencies; and their commitment to individual self-fulfillment.

Evidence-based policymaking also played a powerful role in shaping the development and institutional design of early childhood policy. As chapter 3 and 4 demonstrate, the behavioral sciences and the rise of the infant mental health movement played a key role in the development of the early childhood policy strategies adopted throughout the two-thousands. In the case of intervention policy development, federal policy makers have stipulated that federal funds are contingent upon states developing standardized systems that document outcomes and by selecting home visitation contractors that use evidence based home visitation practices.

At the service delivery level, this logic has bred the adoption of multiple instrumental strategies in which health policy interventions are selectively invoked to accomplish predetermined goals. One key consequence has been that marginalized families are subjected to participating in vast surveillance systems that document their children's development, their emotional health, domestic violence and many other "risk"

factors. The problem with this approach is that these individualistic efforts leave toxic social and structural circumstances intact and potentially contribute to future health and social inequities (Cohen, Chavez, and Chehimi 2010; Israel et al. 1998; Tricket and Beehler 2013). Moreover, interventions aimed at changing individual behaviors are incapable of substantially changing the distribution of health outcomes within a population (Institute of Medicine 2000).

Chapter 4 shows that at least at the state level, the intense focus on improving parental behavioral outcomes has slowly squeezed out financial support for traditional wrap around services such as case management. Community based home visitation programs have relied on these resources to work with families in a holistic manner to help them address their structural needs. But in a world of clinically based home visitation, agencies are increasingly forced to reduce their intervention work to completing risk screenings, cultivating parenting skills, and making referrals to clinicians who can rehabilitate mothers and their children. What's more, the increasing professionalization of home visitors and "infant mental health specialists" is squeezing out lay community health workers from this form of service delivery. Lay community health workers, who are often members of the local community, serve as powerful brokers between marginalized groups and formal institutions.

I also contribute to our understanding of the possibility of social service provision to enable individuals and communities to assume mastery over their own lives and to transform power relations between communities, institutions and public agencies (Wallerstein 2006). Similar to the scholarship that has documented the discourse and practice of paternalism, the evidence presented here suggests that home visitation does

indeed conform to a paternalistic logic. A unique contribution of this study is that it moves beyond describing the characteristics of paternalism by revealing how this medicalized approach emerged both discursively and through the concrete practices of early childhood professionals.

In chapter 3, I trace how the medicalization of motherhood stems from the welfare state's preoccupation with the successful development of the modern child and the nuclear family (Rose 1996). The child, as an idea and target of intervention, has become the focus of a number of projects designed to safeguard them from physical and emotional harm, to ensure their 'normal' development, and to actively promote capacities such as intelligence and emotional stability. Often times, these projects are grounded in the language of psychology with common references to maternal deprivation, bonding between the mother and child, and fostering maternal competency. Importantly, the language of these projects reflects the influence of psychoanalytic ideas on mothering and parenting more generally.

The success of these ideas stems at least in part, by their ability to bestow a certain glamour on everyday life (Illouz 2008). Such an outlook suggests that life is full of events that are worth noticing, interpreting and acting upon. Given its intense focus on the domestic sphere, the nuclear family occupies a central space as it is deemed the cause and foundation of one's emotional life. By focusing on banal occurrences (feeding, playing etc.), home visitation makes the un-meaningful, the trivial, and the ordinary, full of meaning for the formation of the self. This psychoanalytic discourse has arguably had a critical impact on how individuals perceive the self because it not only connects the everyday with health, but health becomes the ideal. Perhaps more significantly, this

reasoning “links in a single etiological chain health and pathology, thus establishing a body of knowledge with the aim of addressing both pathological and healthy people” (Illouz 2008,42).

In this way, successful child rearing has been linked to the necessity of authorities that offer the expertise and knowledge to guide mothers through the minutiae of parenting. Infant feeding for example, is more than a task of nourishment. It fosters a ‘feeding relationship’ between the mother and infant and when this relationship becomes difficult, professionals must work to ‘empower’ parents to foster the skills to build their natural capacities. My analysis of the development of early childhood programs demonstrates an increasing emphasis on fostering appropriate mother-child relationships—particularly among the poor. A key rationale behind these policies has been to break the cycle of poverty by producing emotionally healthy children and mothers. In short, states have implemented a number of programs and initiatives that have established a perceptual system in which mothers are encouraged to speak about and evaluate themselves and their emotions in relation to their children.

Consequently, successful child rearing has been inextricably linked to state institutions that regulate children’s development financially through benefits and support to the family, through education, and through a multitude of programs designed to foster the development of parents to be. Importantly, these trajectories have been organized along class lines. Upper middle class children are groomed to maximize their potential through a constellation of practices that enable them to promote their lineage and secure their professional future. Poor children and their mothers, on the other hand, have been subject to a variety of state interventions that seek to minimize “the threat to social

wellbeing that the future adult might represent, by supplementing the work of the mother in various ways and by training her in the correct ways of conducting her tasks” (Rose 1999, 182). In this way, evidence-based home visitation programs that focus on altering individual behaviors without attention to contextual influences may further exacerbate health and social inequities because those with greater advantage may benefit more from these interventions (Frohlich and Potvin 2008).

At the organizational level, the ethnography reveals that universal, evidenced based home visitation models reinforce class divisions in child rearing practices and often marginalize poor fathers. Indeed, middle class participants in home visitation commonly remarked that the intervention improved their parenting skills, and enhanced their ability to adopt multiple strategies to cultivate the cognitive and social-emotional growth of their children. Poor and working class parents cited similar benefits, but they were also adamant that they continued to feel isolated and they longed for stronger support networks with other parents who shared their concerns.

At the individual level, home visitation practices sometimes contain nefarious consequences for individuals. As chapter 4 demonstrates, service intervention premised on a manualized training curriculum often silences local knowledge and influence and forces frontline staff workers to carry out the “science” devised by others (Trickett 2011). In chapter 4, I highlight how this indirect process of stigmatization occurs by privileging western forms of child rearing and ignoring indigenous knowledge; by deflecting client’s structural concerns; by privileging middle class parenting practices; and by reinforcing spatial stigmas by imposing solutions that do not acknowledge the environmental

struggles faced by marginalized communities. By fixating on risks, home visitors miss crucial opportunities to build on the strengths of families and communities.

Policy Solutions

After taking a long look at social service provision in the U.S., as both a service provider and a scholar, my practical work with marginalized communities and the study presented here bare the urgent need to ask how the social and health policies presented here might be re-imagined to promote a fairer and more just society. At a minimum, we must begin with the premise that poverty is not primarily a problem about income. It is more fundamentally a condition of marginality and deprivation in which people are denied the capabilities they need to lead the kinds of lives that **all** humans value and to participate effectively in defining the relations and institutions of their community (Minkler et al. 2008; Sen 1999; Soss, Fording and Schram 2011).

First, it would serve democracy well by enhancing people's abilities to participate in decisions that shape their lives, to check arbitrary uses of authority, and to reconfigure the terms of the relations between service providers and members of the community (Mettler 2011; Soss 1999). In a society where policy making is distal and is increasingly becoming a spectacle of clashing ideologies, public bureaucracies and private agencies afford marginalized groups with their most immediate experiences with government. As this research demonstrates, these experiences not only provide individuals with scripts on how they should expect the government to act, but they serve as an active force in the ordering of social relations (Esping-Andersen 1990). As others have demonstrated, individuals that participate in social and health programs with strong community advisory boards are more likely to report higher feelings of external and internal efficacy

compared to programs that lack mechanisms for feedback (Soss 1999). For instance, Head Start requires parents to participate in policy councils and local decision making processes to encourage the maximum participation of parents in the program. In this early childhood program, marginalized parents are brought together to deliberate and make organizational policy. Parental policy councils formalize the expectation that participants will speak out. This tells parents that they make decisions about how the program works. In this way, parents are given power and voice and the message is clear, the agency serves their interests, not the other way around.

In addition to implementing more formal community advisory boards, another solution is to support multilevel interventions that position the community as the unit of identity and as the site where solutions and practices unfold (Eng, Hatch and Callan 1985; Katz et al. 2011; Trickett and Beehler 2013). Multilevel interventions are social and health interventions with multiple components designed to affect factors in two or more levels of the “local ecology” that contribute to wellness and social equity (Bronfenbrenner 1979). This framework describes individual behavior as nested within multiple levels, or systems of influence--each of which may exercise direct or indirect impacts on individual behavior. This approach to social service delivery places individual behavior and change in an ecological context, which locates health and social inequities in the context of cultures, norms, and power dynamics. Related to equity, multilevel interventions must target the social determinants of health and social inequities at multiple levels because these create and maintain health inequities. For example, evidence from community psychology, applied anthropology, and public health suggests that inequities can be reduced by altering social policies, strengthening institutional

resources, and supporting the development of community leaders and advocacy organizations in key community settings (Schensul 2005; Trickett 2009).

Families United undoubtedly takes a multilevel approach to reducing social and health inequities as evidenced by chapter 4. Indeed, there is evidence that they vociferously advocate for poverty reduction at the state level. A critical shortcoming, however, is that the voice of marginalized communities is absent from organizational decision making. Moreover, their manualized approach to service delivery is predicated on a specific formula of standard components of interventions that are linked to precise individual outcomes. This, in many ways, demonstrates one of the flaws of evidence based health interventions. The misalignment between poor clients' lived experiences and the "curriculum," suggests that scientific findings need to be re-contextualized through local participation (Trickett 2011). Randomized control trials can reveal important pathways of change, but the solution may be to standardize the functions of successful interventions rather than their specific form or content (Hawe, Shiell, and Riley 2004). For instance, if the goal of an intervention is to prevent maternal depression, rather than standardize a maternal depression information kit, agencies should have the freedom to work with their communities to devise their own strategies tailored to the literacy, language, and sociopolitical factors in the community of interest.

Finally, stability and development in lower income communities will be thwarted at every turn as long as public investments do not take a more proactive approach to creating good jobs, setting stronger wage and benefit floors, and ensuring rights to collective bargaining. For lower income Americans, this includes expanding public supports that ensure reliable access to child care, health care, transportation and wage

supports. The fact is that poor women with children are already working, and their wage work must be compatible with the care work that they **must** provide (Collins and Mayer 2010). To live up to the values of justice, care and democracy we must continue to struggle to create public policies that are responsive to the challenges and strengths of poor women and their children

Technical Appendix A: Measurement Strategies for Adoption and Repeal of Family Caps

Family Caps

Family Cap Adoption/Repeals: For the models that analyze the determinants of family cap adoption, the dependent variable in the analysis is dichotomous and is coded 1 for all states that adopted the family cap, 0 for non-adopters, and missing after the policy is adopted. The coding scheme is reversed for repeals. Sources: the Urban Institute, the Center for Law and Social Policy (CLASP), state reports and the National Conference on State Legislatures. Adoptions=3.10% Other=96.90. Repeals=.61% other=99.39%

Political Opportunity Structure

Government Ideology 1990-2010: Ideological score for each state government with higher values indicating a more liberal government. Source: William D. Berry, Evan Ringquist, Richard Fording, and Russell Hanson. 1998. "Measuring Citizen and Government Ideology in the American States, 1960- 93." *American Journal of Politics* 42 (January): 327-48.

Data accessed at: <http://rcfording.wordpress.com/state-ideology-data/>. Range=0-92.45 Mean=50.571 Standard Deviation: 24.40

Legislative Party Control 1996-2010: Measures partisan balance in the state legislature. If a party has more than 50 percent of the seats in a chamber for a two-year legislative cycle they are coded as maintaining control. The original variable was coded as 0=Unified Republican Control .5=Neither 1=Unified Democratic Control. The variable was recoded for this analysis with 1=Republican Control 0=other. Source: Carl Klarner. 2013 "State Partisan Balance Data, 1937-2011." Data Accessed at <http://hdl.handle.net/1092.1/2043>. Democrat Control=53.80% Other=46.20%

Policy Diffusion 1990-2010: Years since the first state adopted. Calculated by author. Range=0-22 Mean=10.12 Standard Deviation: 7.03

Social Movement Strength

Social Conservative Group Strength 1990-2010: Percentage of the population that is Catholic and the percentage of the population that belongs to an Evangelical Christian denomination in each state. The total number of evangelical and Catholic adherents divided by the total population. The percent of the state population that are members of these churches was collected for each state in 1990, 2000, and 2010. For 1990 I constructed a measure of total evangelical based on the coding scheme recommended by Glenmary. For 2000 and 2010 I used the aggregate measure that was calculated in the data set. I linearly interpolated the values for the missing years. Sources: The Association of Religion Data Archives from the Glenmary Institute. Religious adherence data was

accessed at: <http://www.glenmary.org/grc/>. Total state population was compiled from the U.S Department of Census. *Percent Catholic in the state*: Range=2.25%-63.12% Mean=18.81 Standard Deviation=12.10. *Percent Evangelical in the state*: Range=1.6%-51.85 Mean=15.93 Standard Deviation= 11.55.

Proportion of Unmarried Mothers in the last 12 Months 1990-2010: Percentage of births in the last 12 months (never married, widowed, divorced) for each state. Source: U.S Census Bureau American Community Survey 1 year estimates. 1990-2010. U.S Center for Disease Control. Vital States Data files. 1990-2010. Data extracted from <http://www.cdc.gov/nchs/VitalStats.htm>. Range= 15.15%-51.2% Mean=32.325 Standard Deviation: 6.09.

Progressive Party Strength: State support for public abortions. This original measure codes the degree to which states support publicly funded abortions from 1990-2010. The ordinal scale is coded 1) the state only pays for abortion in life threatening circumstances 2) the state pays for abortion in cases of life, rape and incest 3) the state pays for abortion in cases of life, rape, incest and other medical conditions 4) the state pays for abortions under court order 5) the state pays for abortions voluntarily. The data was coded from a variety of sources including reports from the Guttmacher institute, state policy reports, and the Kaiser Institute. 1=12.27% 2=45.875 3=8.80% 4=22.13% 5=10.93%.

Social Control

Direct Corrections Spending 1990-2010: Percent of each state's total direct expenditures devoted to corrections spending. Calculated by Author. Source: United States Census Bureau State Revenue and Spending. Range= 1.04% -10.30% Mean=4.25% Standard Deviation: 1.47.

Unemployment Rate 1990-2011: Official unemployment rate for each state, with higher values indicating a higher percentage of the labor force was unemployed. Source: U.S. Bureau of Labor Statistics: Local Area Unemployment. Data extracted and compiled from 1990-2011. Range= 2.3- 13.7%. Mean=5.70% Standard Deviation=1.89.

Race/Demographics

Percent Hispanic 1990-2011: The proportion of Hispanic residents for each state. Source: U.S Census Bureau. Range=9.07% -47.7% Mean=8.31% Standard Deviation=9.25.

Percent Black 1990-2011: The proportion of Black residents for each state. Source: Source: U.S Census Bureau. Range=28.74% -37.7 % Mean=10.04% Standard Deviation=9.46

Appendix B: Federal Policy Documents

Document	Source	Authors	Year	Document Type
The Infant Mental Health Specialist	Zero to Three	Deborah Weatherston	2000	Journal Article
A Science-Based Framework for Early Childhood Policy	Center on the Developing Child	N/A	2007	Policy Brief
Schools, Skills, and Synapses	IZA Institute for the Study of Labor	James Heckman	2008	White Paper
Poverty, Trauma and Infant Mental Health	Zero to Three	Alicia Lieberman Joy Orofsky	2009	Journal Article
Zero to Three Reflections	Zero to Three	N/A	2009	Journal Article
Three Decades of Growth in Infant Mental Health	Handbook of Infant Mental Health	Charles Zeanah Paula Doyle Zeanah	2009	Book Chapter
Home Visitation: The Cornerstone of Effective Early Intervention	N/A	Doborah Daro Ph.D	2009	Testimony
Tracking Services for Infants, Toddlers & Their Families: A Look at Federal Early Childhood Programs and the Role of State and Local Governments	Zero to Three	N/A	2009	Policy Brief
Once Upon a Time, When the Journal Zero to Three Was Born	Zero to Three	Terry Brazelton et al	2009	Journal Article
State-Based Home Visiting: Strengthening Programs through State Leadership	National Center for Children in Poverty	Kim Johnson	2009	Policy Brief
Early Experiences Matter: A Guide to Improved Policies for Infants and Toddlers	Zero to Three	N/A	2009	Policy Brief

A New Agenda for MCH Policy and Programs: Integrating a Life Course Perspective	Family, Maternal and Child Health Programs	Amy Fine Milton Kotelchuck Nancy Adess Cheri Pies	2009	Policy Brief
Home Visitation and Young Children: An Approach Worth Investing In?	Society for Research in Child Development	Jennifer Astuto LaRue Allen	2009	Policy Brief
Rethinking MCH: The Life Course Model as an Organizing Framework	US Department of Health and Human Services Health Resources and Services Administration Maternal and Services	N/A	2010	White Paper
The Foundations of Lifelong Health Are Built in Early Childhood	National Scientific Council on the Developing Child	N/A	2010	White Paper
Reflective Supervision: Supporting Reflection as a Cornerstone of Competency	Zero to Three	Deborah Weatherston R. Weigand B. Weigand	2010	Journal Article
Infant Mental Health and Trauma	Zero to Three	Alicia Lieberman William Harris J. Osofsky H. Osofsky	2010	Journal Article
Ten Years Post-Neurons to Neighborhoods: What's at stake and What Matters in Child Care?	Keynote Address at the Celebration of the 20th Anniversary of CCDGB	Deborah Phillips	2010	Speech
The Case for Investing in Disadvantaged Children	Remarks at the White House Conference on December 16, 2011 Race to the Top - Early Learning Challenge Awards Announcement	James Heckman	2011	Speech

The American Family in Black and White: A Post-Racial Strategy for Improving Skills to Promote Equality	Daedalus, American Academy of Arts and Sciences	James Heckman	2011	Journal Article
Home Visitation Programs: Critical Issues and Future Directions	Early Childhood Research Quarterly	Lenette Azzi-Lessing	2011	Journal Article
Opportunities in Public Policy to Support Infant and Early Childhood Mental Health	American Psychologist	Florence Nelson Tammy Mann	2011	Journal Article
From Neurons to Neighborhoods: What's in it for You?	Zero to Three: National Center for Infants, Toddlers and Families	Emily Fenichel	2011	Journal Article
An Attachment Based Home Visiting Program for Distressed Young Infants	Zero to Three	Marsha Kaitz Naomi Tessler Miriam Chriki	2012	Journal Article
Socioeconomic Status and Cumulative Disadvantage Processes Across the Life Course: Implications for Health Outcomes	Canadian Review of Sociology	Jamie Seabrook William Avison	2012	Journal Article
What is Infant Mental Health	Zero to Three	Joy Osofsky Kandace Thomas	2012	Journal Article
New Research Strengthens Home Visitation Field: The Pew Home Visiting Campaign	Zero to Three	Libby Doggett	2013	Journal Article
White House Summit on Early Education "Going Forward Wisely"	N/A	James Heckman	2014	Speech

Facilitating Mental Health Intervention in Home Visiting	Zero to Three	Sarah Price Lisa A. Gray Dalia El-Khoury	2014	Journal Article
State Policies through a Two-Generation Lens: Strengthening the Collective Impact of Policies That Affect the Life Course of Young Children and Their Parents	National Center for Children in Poverty	Sheila Smith Mercedes Ekono Taylor Robbins	2014	Policy Brief
Thriving Children, Successful Parents: A Two-Generation Approach to Policy	Center for Law and Social Policy	Stephanie Schmit Hannah Matthews Olivia Golden	2014	Policy Brief
Infant, Toddler, And Early Childhood Mental Health Competencies	Zero to Three	Jon Korfmacher	2014	Policy Brief
Epigenetics of the Developing Brain	Zero to Three	Francis Champagne	2015	Journal Article
Home Visiting: Meeting Families Where They Are and Creating Opportunity	Zero to Three	N/A	2015	Policy Brief
Build a Scaffolding of Support: A comprehensive approach to human development pays off.	heckmanequation.org	James Heckman	2015	Policy Brief
Inbrief: Early Childhood Mental Health	Center on the Developing Child	N/A	2015	Policy Brief
Inbrief: The Foundations of Lifelong Health	Center on the Developing Child	N/A	2015	Policy Brief
Connecting Science, Policy, and Practice	Zero to Three	N/A	2015	Policy Brief

An Investment in Our Future: How Federal Home Visiting Funding Provides Critical Support for Parents and Children	Center for Law and Social Policy	Stephanie Shchmit Christina Walker Rachel Herzfeldt-Kamprath	2015	Policy Brief
Early Childhood Policy: Implications for Infant Mental Health	Brandeis University	Jack Shonkoff M.D John Lippitt Doreen Cavanaugh	N/A	White Paper
Strengthening Adult Capacities to Improve Child Outcomes: A New Strategy for Reducing Intergenerational Poverty	Spotlight on Poverty and Opportunity	Jack Shonkoff	N/A	Policy Brief

References

- Abers, Rebecca N, and Margaret E Keck. 2013. *Practical Authority: Agency and Institutional Change in Brazilian Water Politics*. Oxford: NY. Oxford University Press.
- Abramovitz, Mimi. 2006. "Welfare Reform in the United States: Gender, Race and Class Matter." *Critical Social Policy* 26 (2):336-364.
- Adam, Silke, and Hanspeter Kriesi. 2007. "The Network Approach." *Theories of the Policy Process* 2:189-220.
- Adkins, Jason. "MCC 'Family Cap' Repeal Testimony." Testimony provided at Minnesota Catholic Conference, February 25, 2013. <http://www.mncc.org/mcc-family-cap-repeal-testimony/>.
- Adorno, Theodor W, Else Frenkel-Brunswik, Daniel J Levinson, and R Nevitt Sanford. 1950. *The Authoritarian Personality*. New York, NY: Harper and Brothers.
- Ainsworth, Mary S. 1979. "Infant–Mother Attachment." *American Psychologist* 34 (10):932.
- Airhihenbuwa, Collins O. 1995. *Health and Culture: Beyond the Western Paradigm*. Los Angeles: Sage.
- Anderson, JH, and Axel Honneth. 2005. "Autonomy, Vulnerability, Recognition, and Justice." In *Autonomy and the Challenges to Liberalism: New Essays*, eds. J Christman and J Anderson. Cambridge: Cambridge University Press. (127-149).
- Annie E Casey Foundation. 2013 *KIDS COUNT* Data Book. <http://datacenter.kidscount.org/data#NM/2/0>.
- Annie E. Casey Foundation. 2012. *Double Jeopardy: How Third-Grade Reading Skills and Poverty Influence High School Graduation*. Baltimore: The Annie E. Casey Foundation, 2012. <http://www.aecf.org/resources/double-jeopardy/>.
- Armstrong, David. 1995. "The Rise of Surveillance Medicine." *Sociology of Health & Illness* 17 (3):393-404.
- Arnold, David H, and Greta L Doctoroff. 2003. "The Early Education of Socioeconomically Disadvantaged Children." *Annual Review of Psychology* 54 (1):517-545.
- Astuto, Jennifer, and LaRue Allen. 2009. "Home Visitation and Young Children: An Approach Worth Investing In? Social Policy Report. Volume XXIII, Number IV." *Society for Research in Child Development*.
- Atworth, Jullan, G Arachi, and R Hamaul. 2003. "Fiscal Federalism and Welfare Policy: The Role of States in the Growth of Child SSI." *National Tax Journal* 56 (1): 61-79.
- Avery, J. and M. Peffley 2005. "Class Bias in State Electorates and the Adoption of Restrictive Welfare Policies After TANF." *State Politics and Policy Quarterly* 5 (1):47-67.
- Baird, Karen L, Dāna-Ain Davis, and Kimberly Christensen. 2009. *Beyond*

Reproduction: Women's Health, Activism, and Public Policy. Madison, NJ: Fairleigh Dickinson University Press.

- Banaszak, Lee Ann. 2005. "Inside and Outside the State: Movement Insider Status, Tactics, and Public Policy Achievements." In *Routing the Opposition: Social Movements, Public Policy, and Democracy*, eds. D Meyer, V Jenness, and H Ingram. Minneapolis: University of Minnesota Press. (149-176).
- Bapat, S. 2013. "Repealing Welfare Family Cap Laws a Common Goal for Some Pro- and Anti-Choice Groups." *Rewire News*, August 21.
- Barrilleaux, Charles, Thomas Holbrook, and Laura Langer. 2002. "Electoral Competition, Legislative Balance, and American State Welfare Policy." *American Journal of Political Science* 46 (2):415-427.
- Barrera, M. 1979. *Race and Class in the Southwest: A Theory of Racial Inequality*. Notre Dame, IN: University of Notre Dame Press.
- Barron, C. and N. Paradis. 2010. "Infant Mental Health Home Visitation." *Zero to Three* 30(6): 38-43.
- Bartels, Brandon. 2008. "Beyond 'Fixed Versus Random Effects': A Framework for Improving Substantive and Statistical Analysis of Panel, Time-Series Cross-Sectional, and Multilevel Data." *The Society for Political Methodology*: 1-43.
- Beach, Derek, and Rasmus Brun Pedersen. 2013. *Process-Tracing Methods: Foundations and Guidelines*. Ann Arbor, Michigan: University of Michigan Press
- Ben-Ishai, Elizabeth. 2012. *Fostering Autonomy: A Theory of Citizenship, the State, and Social Service Delivery*. University Park, PA: Penn State Press.
- Berlant, Lauren Gail. 1997. *The Queen of America Goes to Washington City: Essays on Sex and Citizenship*. Durham, NC: Duke University Press.
- Bernstein, Anya E. 2001. *The Moderation Dilemma: Legislative Coalitions and the Politics of Family and Medical Leave*. University Park, PA: University of Pittsburgh Press.
- Berry, Jeffrey M. 1999. "The Rise of Citizen Groups." In Theda Skocpol and Morris Fiorina *Civic Engagement in American Democracy*. Washington, DC: Brookings Institution Press. (367-394).
- Berry, William D, Evan J Ringquist, Richard C Fording, and Russell L Hanson. 1998. "Measuring Citizen and Government Ideology in the American States, 1960-93." *American Journal of Political Science* 42 (1):327-348.
- Bevir, Mark, and David Richards. 2009. "Decentering Policy Networks: A Theoretical Agenda." *Public Administration* 87 (1): 3-14.
- Bianchi, Suzanne M.; Cohen, Philip N.; Raley, Sara; & Nomaguchi, Kei. 2004. "Inequality in Parental Investment in Child-Rearing: Expenditures, Time, and Health." In Neckerman, Kathryn M. (Ed.) *Social Inequality*. New York: Russell Sage Foundation. (189-219).

- Blackburn, Simon. 2008. *The Oxford Dictionary of Philosophy*. Oxford, UK: Oxford University Press.
- Boehmke, Frederick J. 2009. "Policy Emulation or Policy Convergence? Potential Ambiguities in the Dyadic Event History Approach to State Policy Emulation." *The Journal of Politics* 71 (3):1125-1140.
- Bourdieu, Pierre. 1999. "Site Effects." in P. Bourdieu (Ed.) *The Weight of the World: Social Suffering in Contemporary Society*. Stanford, CA: Stanford University Press. (123-129).
- Bourdieu, Pierre. 1986. "The Forms of Capital." In Imre Szeman and Timothy Kaposy 2011 *Cultural Theory: An Anthology*. Malden, MA: John Wiley & Sons. (81-93).
- Bowlby, John. 1952. "Maternal Care and Mental Health: A Report Prepared On Behalf of the World Health Organization as A Contribution to The United Nations Programme for The Welfare of Homeless Children." Vol. 2: Geneva: WHO.
- Boyer, Paul, Clifford Clark, Joseph Kett, Neal Salisbury, and Harvard Sitkoff. 2007. *The Enduring Vision: A History of the American People*. Boston: Cengage Learning.
- Braun, Dietmar, and Fabrizio Gilardi. 2006. "Taking 'Galton's Problem' Seriously Towards a Theory of Policy Diffusion." *Journal of Theoretical Politics* 18 (3):298-322.
- Bright, Elise M. 2003. *Reviving America's Forgotten Neighborhoods: An Investigation of Inner City Revitalization Efforts*. New York: Routledge.
- Bronfenbrenner, U. 1979. *Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University press.
- Brown, Phil, Stephen Zavestoski, Sabrina McCormick, Brian Mayer, Rachel Morello-Frosch, and Rebecca Gasior Altman. 2004. "Embodied Health Movements: New Approaches to Social Movements in Health." *Sociology of Health & Illness* 26 (1):50-80.
- Brown, Wendy. 2003. "Neo-Liberalism and the End of Liberal Democracy." *Theory & Event* 7 (1):1-25.
- Buchanan, David. 2008. "Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health." *American Journal of Public Health* 98 (1):15-21.
- Buhler-Wilkerson, K. 1985. "Public Health Nursing: In Sickness or in Health?" *American Journal Public Health* 75 (10): 1155-1161.
- Camasso, Michael. 2007. *Family Caps, Abortion and Women of Color: Research Connection and Political Rejection*. Oxford, UK: Oxford University Press.
- Camasso, Michael J, and Radha Jagannathan. 2009. "How Family Caps Work: Evidence from a National Study." *Social Service Review* 83 (3):389-428.
- Campbell, A. 2011. "Policy Feedbacks and The Impact of Policy Designs on Public Opinion." *Journal of Health Politics, Policy, and Law* 36 (6): 961-973.

- Cazenave, N, and K Neubeck 2001. "Fighting Welfare Racism." *Poverty & Race, Poverty & Race Research Action Council* 10(2): 1-2.
- Center on the Developing Child. 2007. *A Science-Based Framework for Early Childhood Policy*. www.developingchild.harvard.edu.
- Cherlin, Andrew. 2009. *Marriage, Divorce, Remarriage*. Cambridge, MA: Harvard University Press.
- Christman, John. 2005. "Saving Positive Freedom." *Political Theory* 33 (1):79-88.
- Cohen, Jean L 2002. *Regulating Intimacy: A New Legal Paradigm*. Princeton, NJ: Princeton University Press.
- Cohen, J, N Onunaku, S Clothier, and J Poppe. 2005. "Helping Young Children Succeed: Strategies to Promote Early Childhood Social and Emotional Development." *Brief: The National Conference of State Legislatures*.
- Cohen, Jeffrey E, and C Barrilleaux. 1993. "Public Opinion Interest Groups and Public Policy Making. Abortion Policy in the American states." In Malcolm Goggin (Ed.) *Understanding the New Politics of Abortion*. Newbury Park, CA: Sage.
- Cohen, Larry, Vivian Chavez, and Sana Chehimi. 2010. *Prevention is Primary: Strategies for Community Wellbeing*. Hoboken, NJ: John Wiley & Sons.
- Coll, Cynthia Garcia, Gontran Lamberty, Renee Jenkins, Harriet Pipes McAdoo, Keith Crnic, Barbara Hanna Wasik, and Heidie Vazquez Garcia. 1996. "An Integrative Model for The Study of Developmental Competencies in Minority Children." *Child Development* 67 (5):1891-1914.
- Collier, Ruth Berins, and David Collier. 2002. *Shaping the Political Arena*. Notre Dame, IN: University of Notre Dame Press.
- Collins, Jane L, and Victoria Mayer. 2010. *Both Hands Tied: Welfare Reform and the Race to the Bottom in the Low-Wage Labor Market*. Chicago: University of Chicago Press.
- Conlan, Timothy J. 1998. *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform*. Washington, DC: Brookings Institution Press.
- Cook, Elizabeth Adell, Ted G Jelen, and Clyde Wilcox. 1992. "Between Two Absolutes: Public Opinion and the Politics of Abortion." *Signs* 20 (3):732-738.
- Coontz, Stephanie. 2007. "The Origins of Modern Divorce." *Family Process* 46 (1):7-16.
- Corburn, Jason. 2009. *Toward the Healthy City: People, Places, and the Politics of Urban Planning*. Cambridge, MA: MIT Press.
- Cossman, Brenda. 2005. "Contesting Conservatism, Family Feuds and the Privatization of Dependency." *American University Journal of Gender, Social Policy, and Law* 13 (3):415-509.
- Crenson, M, and B Ginsberg 2002. *Downsizing Democracy: How America Sidelined Its Citizens and Privatized Its Public*. Baltimore, MD: John Hopkins University Press.

- Cress, D, and D Snow 2000. "The Outcomes of Homeless Mobilization: The Influence of Organization, Disruption, Political Mediation, and Framing." *American Journal of Sociology* 105 (4):1063-1104.
- Cruikshank, Barbara. 1999. *The Will to Empower: Democratic Citizens and Other Subjects*. Ithaca, NY: Cornell University Press.
- Cunha, Flavio, James J Heckman, Lance Lochner, and Dimitriy V Masterov. 2006. "Interpreting the Evidence on Life Cycle Skill Formation." In *Handbook of the Economics of Education*, eds. Hanushek and Welch. Amsterdam: Eslevier (697-812).
- Daly, Sharon M. and Deborah Lewis. 1994, "Unlikely Allies Oppose Welfare Reform Policy." *Chicago Tribune*, November 30, 1994.
http://articles.chicagotribune.com/1994-11-30/news/9411300077_1_poor-women-child-exclusion-catholic-charities-usa
- De Genova, Nicholas. 2004. "The Legal Production of Mexican / Migrant 'Illegality'." *Latino Studies* 2 (2):160-185.
- De Genova, Nicholas, and Ana Y Ramos-Zayas. 2003. *Latino Crossings: Mexicans, Puerto Ricans, and the Politics of Race and Citizenship*. Hove, UK: Psychology Press.
- DeFilippis, James, Robert Fisher, and Eric Shragge. 2010. *Contesting Community: The Limits and Potential of Local Organizing*. New Brunswick, NJ: Rutgers University Press.
- Dias, Janice Johnson, and Steven Maynard-Moody. 2007. "For-Profit Welfare: Contracts, Conflicts, and the Performance Paradox." *Journal of Public Administration Research and Theory* 17 (2):189-211.
- Diez Roux, Ana V, and Christina Mair. 2010. "Neighborhoods and Health." *Annals of the New York Academy of Sciences* Feb; 1186 (1):125-145.
- Dodge, Jennifer, Sonia M Ospina, and Erica Gabrielle Foldy. 2005. "Integrating Rigor and Relevance in Public Administration Scholarship: The contribution of Narrative Inquiry." *Public Administration Review* 65 (3):286-300.
- Dodson, Christopher. 2001 "Testimony on Senate Bill 2414 (Repeal of Family Cap)." Testimony provided at North Dakota Catholic Conference, February 7, 2001.
<http://www.ndcatholic.org/archives/familycaps/index.html>.
- Dodson, Debra L. 2001. *Acting for Women: Is What Legislators Say, What They Do?* Bloomington, IN: Indiana University Press.
- Dutta, Mohan J. 2007. "Communicating About Culture and Health: Theorizing Culture-Centered and Cultural Sensitivity approaches." *Communication Theory* 17 (3):304-328.
- Dutta, Mohan J. 2008. *Communicating Health: A Culture-Centered Approach*. Cambridge, U.K.: Polity.

- Edelman, Murray. 1977. "The Language of Participation and the Language of Resistance." *Human Communication Research* 3 (2):159-170.
- Elwood, Sarah. 2006. "Beyond Cooptation or Resistance: Urban Spatial Politics, Community Organizations, and GIS-Based Spatial Narratives." *Annals of the Association of American Geographers* 96 (2):323-341.
- Emde, Robert N. 1983. "The Prerepresentational Self and its Affective Core." *The Psychoanalytic Study of the Child* 38:165-92.
- Eng, Eugenia, John Hatch, and Anne Callan. 1985. "Institutionalizing Social Support Through the Church and into the Community." *Health Education & Behavior* 12 (1):81-92.
- Erikson, Robert S, Gerald C Wright, and John P McIver. 1993. *Statehouse Democracy: Public Opinion and Policy in the American States*. Cambridge, MA: Cambridge University Press.
- Erler, Abbie. 2013. "A New Face of Poverty? Economic Crises and Poverty Discourses." *Poverty and Public Policy* 4(4):183-204.
- Ermisch, John, Markus Jantti, and Timothy Smeeding, eds. 2012. *From Parents to Children: The Intergenerational Transmission of Advantage*. New York: Russell Sage Foundation.
- Esping-Anderson, Gosta. 1990. *The Three Worlds of Welfare Capitalism*. Cambridge, MA: Polity Press.
- Esping-Andersen, Gosta. 2009. *Incomplete Revolution: Adapting Welfare States to Women's New Roles*. Cambridge, UK: Polity.
- Fassin, Didier, and Richard Rechtman. 2009. *The Empire of Trauma: An Inquiry into the Condition of Victimhood*. Princeton, NJ: Princeton University Press.
- Fellowes, Matthew C, and Gretchen Rowe. 2004. "Politics and the New American Welfare States." *American Journal of Political Science* 48 (2):362-373.
- Fine, Amy and Milton Kotelchuck. 2010. "Rethinking MCH: The Life Course Model as an Organizing Framework." Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.
- Fitzgerald, Hiram E, Deborah Weatherston, and Tammy L Mann. 2011. "Infant Mental Health: An Interdisciplinary Framework for Early Social and Emotional Development." *Current Problems in Pediatric and Adolescent Health Care* 41(7): 178-182.
- Fitzgerald, Hiram E, and Lauren R Barton. 2000. *Infant Mental Health: Origins and Emergence of an Interdisciplinary Field*. New York: John Wiley & Sons, Inc.
- Fox, Cybelle. 2004. "The Changing Color of Welfare? How Whites' Attitudes Toward Latinos Influence Support for Welfare." *American Journal of Sociology* 110 (3):580-625.

- Fox, C. 2012. *Three Worlds of Relief: Race, Immigration, and the American Welfare State from the Progressive Era to the New Deal*. Princeton, NY: Princeton University Press.
- Fraiberg, Selma, Edna Adelson, and Vivian Shapiro. 1975. "Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships." *Journal of the American Academy of Child Psychiatry* 14 (3):387-421.
- Frank, Alan, Patricia T Clough, and Steven Seidman. 2013. *Intimacies: A New World of Relational Life*. London, UK: Routledge.
- Fraser, Nancy, and Linda Gordon. 1994. "A Genealogy of Dependency: Tracing a Keyword of the U.S Welfare State." *Signs* 19 (2):309-336.
- Friedman, Marilyn. 2005. *Women and Citizenship*. Online: Oxford Scholarship.
- Frohlich, Katherine L, and Louise Potvin. 2008. "Transcending the Known in Public Health Practice: The Inequality Paradox: The Population Approach and Vulnerable Populations." *American Journal of Public Health* 98 (2):216-221.
- Füredi, Frank. 2004. *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. Hove, UK: Psychology Press.
- Gans, Herbert J. 1995. *The War Against the Poor: The Underclass and Antipoverty Policy*. New York: Basic Books.
- Gastly, Kelly J. 2004. "Why Family Cap Laws Just Aren't Getting it Done." *William & Mary Law Review* 46 (1):373-414.
- George, Alexander and Andrew Bennett. 2005. *Case Studies and Theory Development in the Social Sciences*. Cambridge, MA: MIT Press.
- Geronimus, Arline T, and J Phillip Thompson. 2004. "To Denigrate, Ignore, or Disrupt: Racial Inequality in Health and the Impact of a Policy-Induced Breakdown of African American Communities." *Du Bois Review* 1 (2):247-279.
- Gieryn, Thomas F. 2000. "A Space for Place in Sociology." *Annual Review of Sociology* 26 (1):463-496.
- Gilardi, Fabrizio. 2010. "Who Learns from What in Policy Diffusion Processes?" *American Journal of Political Science* 54 (3):650-666.
- Gilens, Martin. 1996. "'Race Coding' and White Opposition to Welfare." *American Political Science Review* 90 (3):593-604.
- Gilens, Martin. 2001. "Political Ignorance and Collective Policy Preferences." *The American Political Science Review* 95 (2):379-396.
- Gilens, Martin. 2003. "How the Poor Became Black." In *Race and the Politics of Welfare Reform*, eds. Sanford Schram, Joe Soss, and Richard Fording. Ann Arbor, Michigan: University of Michigan Press. (101-130).
- Gilens, Martin. 1999. *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy*. Chicago: University of Chicago Press.

- Gillies, Val. 2005. "Raising the 'Meritocracy' Parenting and the Individualization of Social Class." *Sociology* 39 (5):835-853.
- Goggin, Malcolm L. 1993. "Understanding the New Politics of Abortion a Framework and Agenda for Research." *American Politics Quarterly* 21 (1):4-30.
- Gold, Rachel Benson, Adam Sonfield, Cory L Richards, and Jennifer J Frost. 2009. *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*. New York: Guttmacher Institute.
- Goldman, Howard H, and Joseph P Morrissey. 1985. "The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform." *American Journal of Public Health* 75 (7):727-731.
- Gómez, L. E. 2007. *Manifest Destinies: The Making of the Mexican American Race*. New York: NYU Press.
- Gordon, Linda. 1994. *Pitied but Not Entitled: Single Mothers and the Origins of Welfare*. New York: Free Press.
- Graham, Erin R, Charles R Shipan, and Craig Volden. 2013. "The Diffusion of Policy Diffusion Research in Political Science." *British Journal of Political Science* 43 (03):673-701.
- Gray, Ron, and Marie C McCormick. 2005. "Early Childhood Intervention Programs in the U.S: Recent Advances and Future Recommendations." *Journal of Primary Prevention* 26 (3):259-275.
- Greene, Jennifer C, Valerie J Caracelli, and Wendy F Graham. 1989. "Toward a Conceptual Framework for Mixed-Method Evaluation Designs." *Educational Evaluation and Policy Analysis* 11 (3):255-274.
- Grossback, Lawrence J, Sean Nicholson-Crotty, and David AM Peterson. 2004. "Ideology and Learning in Policy Diffusion." *American Politics Research* 32 (5):521-545.
- Hacker, Jacob S. 2004. "Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States." *American Political Science Review* 98 (02):243-260.
- Hajer, Maarten A, and Hendrik Wagenaar. 2003. *Deliberative Policy Analysis: Understanding Governance in the Network Society*. Cambridge, UK: Cambridge University Press.
- Halfon Neal. 2009. "Life Course Health Development: A New Approach for Addressing Upstream Determinants of Health and Spending." Washington, DC: Expert Voices, NIHCM Foundation.
- Hall, Peter A, and Rosemary CR Taylor. 1996. "Political Science and the Three New Institutionalisms." *Political Studies* 44 (5):936-957.
- Hamburg, David. 1987. "Early Intervention to Prevent Lifelong Damage: Lessons from Current Research." *Testimony for the Senate Committee on Labor and Human*

Resources and the House Committee on Education and Labor.

- Hancock, Ange-Marie. 2004. *The Politics of Disgust: The Public Identity of the welfare Queen*. New York: NYU Press.
- Harden, Brenda Jones. 2010. "Home Visitation with Psychologically Vulnerable Families." *Zero to Three* 30 (6): 44-51.
- Hawe, Penelope, Alan Shiell, and Therese Riley. 2004. "Complex Interventions: How 'Out of Control' Can a Randomized Controlled Trial Be?" *British Medical Journal* 328:1561-1563.
- Heckman, James J. 2000. "Policies to Foster Human Capital." *Research in Economics* 54 (1):3-56.
- Heckman, James J. 2012. "Invest in Early Childhood Development: Reduce Deficits, Strengthen the Economy." *The Heckman Equation* (blog), <http://heckmanequation.org/content/resource/invest-early-childhood-development-reduce-deficits-strengthen-economy>.
- Hecl, H. 1978. "Issue Networks and the Executive Establishment." *Public Administration Concepts Cases* 413:46-57.
- Heidenheimer, A, Hugh Hecl, Carolyn Teich Adams, T Alexander Smith, Jack Hayward, and Michael Watson. 1978. *Comparative Public Policy: The Politics of Social Choice in Europe and America*. Boston: Bedford-St. Martin's.
- Heritage Foundation. 2013. "Welfare and Welfare Spending: Marriage and Poverty." <http://www.heritage.org/issues/welfare/marriage-and-poverty>
- Herman, Ellen. 1996. *The Romance of American Psychology: Political Culture in the Age of Experts*. Berkeley: University of California Press.
- Hernandez, DJ. 2011. "Double Jeopardy: How Third-Grade Reading Skills and Poverty Influence High School Graduation." Annie E. Casey Foundation.
- Hook, Jennifer L, and Christina M Wolfe. 2012. "New Fathers? Residential Fathers' Time with Children in Four Countries." *Journal of Family Issues* 33 (4):415-450.
- Horwitz, Allan V. 2002. *Creating Mental Illness*. Chicago: University of Chicago Press.
- Howard, Christopher. 1999. *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States*. Princeton, NJ: Princeton University Press.
- Huber, Evelyne, Charles Ragin, and John D Stephens. 1993. "Social democracy, Christian Democracy, Constitutional Structure, and the Welfare State." *American Journal of Sociology* 99(3):711-749.
- Illouz, Eva. 2008. *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help*. Oakland, CA: University of California Press.
- Ingram, Helen, and Anne L Schneider. 1995. "Social Construction (continued): Response." *The American Political Science Review* 89 (2):441-446.

- Ingram, Helen, Anne L Schneider, and Peter De Leon. 2007. "Social Construction and Policy Design." *Theories of the Policy Process* 2:93-126.
- Institute of Medicine (US) Committee on Health and Behavior: Research, Practice, and Policy. 2001. "Individuals and Families: Models and Interventions." In *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences*. Washington, DC: National Academies Press.
- Israel, Barbara A, Amy J Schulz, Edith A Parker, and Adam B Becker. 1998. "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health." *Annual Review of Public Health* 19 (1):173-202.
- Iyengar, S. 1990. "Framing Responsibility for Political Issues: The case of Poverty." *Political Behavior* 12(1): 19-40.
- Johnson, Kay. 2009. State-based Home Visiting: Strengthening Programs Through State Leadership, Columbia University Academic Commons, <http://hdl.handle.net/10022/AC:P:8889>.
- Jordan, Andrew, Rüdiger K, W Wurzel, and Anthony Zito. 2005. "The Rise of 'New' Policy Instruments in Comparative Perspective: Has Governance Eclipsed Government?" *Political Studies* 53 (3):477-496.
- Katz, David, Mary Murimi, Anjelica Gonzalez, Valentine Njike, and Lawrence Green. 2011. "From Controlled Trial to Community Adoption: The Multisite Translational Community Trial." *American Journal of Public Health* 101 (8):e17-e27.
- Katz, Michael. 1986. "Reorganizing the Labor Market." In *The Shadow Of the Poorhouse: A Social History Of Welfare In America*, ed. Michael Katz. New York: BasicBooks.
- Katzenstein, Mary Fainsod. 1999. *Faithful and Fearless: Moving Feminist Protest Inside the Church and Military*. Princeton, NJ: Princeton University Press.
- Katznelson, Ira. 2005. *When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America*. New York: WW Norton & Company.
- Kaufman, Risa E. 1997. "The Cultural Meaning of the Welfare Queen: Using State Constitutions to Challenge Child Exclusion Provisions." *New York University Review of Law & Social Change* 23 (3):301-329.
- Keane, JT, A Gersick, C Kim, and M Honey. 2003. "Toward a Sustainability Framework: Lessons from the Literature and the Field." In *The Sustainability Challenge: Taking Edtech to the Next Level*, ed. Norris Dickard. New York: Education Development Center. (27-43).
- Kearney, Melissa S, and Phillip B Levine. 2009. "Subsidized Contraception, Fertility, and Sexual Behavior." *The Review of Economics and Statistics* 91 (1):137-151.
- Keene, Danya E, and Mark B Padilla. 2010. "Race, Class and the Stigma of Place: Moving to "Opportunity" in Eastern Iowa." *Health & Place* 16 (6):1216-1223.

- Kettl, Donald F. 2002. "The Transformation of Governance: Public Administration for the 21st Century." Baltimore, MD: Johns Hopkins University.
- Kim, Claire Jean. 2003. *Bitter Fruit: The Politics of Black-Korean Conflict in New York City*. New Haven, CT: Yale University Press.
- King, Desmond S, and Rogers M Smith. 2005. "Racial Orders in American Political Development." *American Political Science Review* 99 (01):75-92.
- Klarner, Carl. 2003. "The Measurement of the Partisan Balance of State Government." *State Politics & Policy Quarterly* 3 (3):309-319.
- Kreitzer, Rebecca J. 2015. "Politics and Morality in State Abortion Policy." *State Politics & Policy Quarterly* 15 (1):41-66.
- Kriesi, Hanspeter. 1995. "The Political Opportunity Structure of New Social Movements: Its impact on Their Mobilization." In *The Politics of Social Protest: Comparative Perspectives on States and Social Movements*, eds. J Craig Jenkins and Bert Klandermans. Minneapolis: University of Minnesota Press. (167-198).
- Ladd-Taylor, M. 1994. *Mother-work: Women, Child Welfare, and the State, 1890-1930 (Vol. 88)*. Urbana: University of Illinois Press.
- Lagemann, Ellen Condliffe. 1999. *Private Power for the Public Good. A History of the Carnegie Foundation for the Advancement of Teaching. [Revised.]*. New York: College Board Publications.
- Lagemann, Ellen Condliffe. 1992. *The Politics of Knowledge: The Carnegie Corporation, Philanthropy, and Public Policy*. Chicago: University of Chicago Press.
- Lareau, Annette. 2002. "Invisible Inequality: Social Class and Childrearing in Black Families and White Families." *American Sociological Review* 67 (5):747-776.
- Lathrop, Julia. 1921. "Hearings on the Public Protection of Maternity and Infancy." in *Public protection of maternity and infancy: hearings before the Committee on Interstate and Foreign Commerce, of the House of Representatives, Sixty-seventh Congress, first session, on H.R. 2366, a bill for the public protection of maternity and infancy and providing a method of cooperation between the government of the United States and the several states*. Washington, DC: United States Congress. House. Committee on Interstate and Foreign Commerce. (241-242).
- Lawless, Angela, John Coveney, and Colin MacDougall. 2014. "Infant Mental Health Promotion and the Discourse of Risk." *Sociology of Health & Illness* 36 (3):416-431.
- Levin-Epstein, Jodie. 2003. "Lifting the Lid Off the Family Cap: States Revisit Problematic Policy for Welfare Mothers." *Center for Law and Social Policy: Childbearing and Reproductive Health Series. Brief* (1).
- Lewin, Tamar. 1995. "Abortion Foes Worry About Welfare Cutoffs." *New York Times*. March 19, 1995.

- Lieberman, Robert C. 2001. *Shifting the Color Line: Race and the American Welfare State*. Hoboken, NJ: John Wiley & Sons.
- Lieberman, Robert C. 2011. *Shaping Race Policy: The United States in Comparative Perspective*. Princeton, NJ: Princeton University Press.
- Lieberman, Robert C, and Greg M Shaw. 2000. "Looking Inward, Looking Outward: The Politics of State Welfare Innovation Under Devolution." *Political Research Quarterly* 53 (2):215-240.
- Lieberman, A, and J Osofsky 2009. "Poverty, Trauma, and Infant Mental Health." *Zero to Three* 30 (2): 54-58.
- Link, Bruce G, and Jo C Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology* 27:363-385.
- Link, Bruce G, and Jo C Phelan. 2006. "Stigma and its Public Health Implications." *The Lancet* 367 (9509):528-529.
- Lipsky, Michael. 1980. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York, Russel Sage Foundation.
- Love, John M, Ellen Eliason Kisker, Christine Ross, Helen Raikes, Jill Constantine, Kimberly Boller, Jeanne Brooks-Gunn, Rachel Chazan-Cohen, Louisa Banks Tarullo, and Christy Brady-Smith. 2005. "The Effectiveness of Early Head Start for 3-year-old Children and Their Parents: Lessons for Policy and Programs." *Developmental Psychology* 41 (6):885-901.
- Lu, Michael C, Cassie B Lauver, Christopher Dykton, Michael D Kogan, Michele H Lawler, Lauren Raskin-Ramos, Kathy Watters, and Lee A Wilson. 2015. "Transformation of the Title V Maternal and Child Health Services Block Grant." *Maternal and Child Health* 19 (5): 927-931.
- Luker, Kristin. 1996. *Dubious Conceptions: The Politics of Teenage Pregnancy*. Cambridge, MA: Harvard University Press.
- Maggetti, Martino, and Fabrizio Gilardi. 2016. "Problems (and solutions) in the Measurement of Policy Diffusion Mechanisms." *Journal of Public Policy* 36 (1): 87-107.
- Mahoney, Christine, and Frank Baumgartner. 2008. "Converging Perspectives on Interest Group Research in Europe and America." *West European Politics* 31 (6):1253-1273.
- Mahoney, James. 2001. *The Legacies of Liberalism: Path Dependence and Political Regimes in Central America*. Baltimore, MD: JHU Press.
- Margie, Nancy Geyelin, and Deborah A Phillips. 1999. *Revisiting Home Visiting: Summary of a Workshop*. Washington, D.C: National Academies Press.
- Margolis, Lewis H, George P Cole, and Jonathan B Kotch. 1997. "Historical Foundations of Maternal and Child Health." In *Maternal and Child Health: Programs, Problems and Policy in Public Health*, ed. Jonathan Kotch. Alphen aan den Rijn, Neatherlands: Aspen Publishers. (19-44).

- Marmot, Michael. 2015. *The Health Gap: The Challenge of an Unequal World*. London, UK: Bloomsbury Publishing.
- Massey, Doreen. 1994. *Place, Space, and Gender*. Cambridge, UK: Polity Press.
- McBeth, Mark K, Michael D Jones, and Elizabeth A Shanahan. 2014. "The Narrative Policy Framework." In *Theories of the Policy Process*, eds. Paul Sabatier and Christopher Weible. Boulder, CO: Westview Press. (225-266).
- McCann, Eugene J. 1999. "Race, Protest, and Public Space: Contextualizing Lefebvre in the U.S. City." *Antipode* 31 (2):163-184.
- Mead, Lawrence M. 1997. *The New Paternalism*. Washington, DC: Brookings Institution Press.
- Mead, Lawrence M. 1998. "Telling the Poor What to Do." *Public Interest* (132):97-112.
- Mead, Lawrence M, and Christopher Beem. 2006. *Welfare Reform and Political Theory*. Los Angeles, CA: Russell Sage Foundation.
- Medoff, Marshall H, Christopher Dennis, and Kerri Stephens. 2011. "The Impact of Party Control on the Diffusion of Parental Involvement Laws in the U.S States." *State Politics & Policy Quarterly* 11(3): 325-347.
- Mehta, Jal, Daniel Béland, and Robert H Cox. 2011. *Ideas and Politics in Social Science Research*. New York: Oxford University Press.
- Meier, Kenneth J, and Deborah R McFarlane. 1993. "The Politics of Funding Abortion State Responses to the Political Environment." *American Politics Quarterly* 21 (1):81-101.
- Meseguer, Covadonga. 2004. "What Role for Learning? The Diffusion of Privatization in OECD and Latin American countries." *Journal of Public Policy* 24 (03):299-325.
- Mettler, Suzanne. 1998. *Dividing Citizens: Gender and Federalism in New Deal Public Policy*. Ithaca, NY: Cornell University Press.
- Mettler, Suzanne. 2011. *The Submerged State: How Invisible Government Policies Undermine American Democracy*. Chicago, IL: University of Chicago Press.
- Mink, Gwendolyn. 1995. *The Wages of Motherhood*. Ithaca, NY: Cornell University Press.
- Mink, Gwendolyn. 1998. *Welfare's End*: Ithaca, NY: Cornell University Press.
- Minkler, Meredith. 2012. *Community Organizing and Community Building for Health and Welfare*. New Brunswick, NJ: Rutgers University Press.
- Minkler, Meredith, and Nina Wallerstein. 2005. "Improving health through community organization." In *Community Organizing and Community Building for Health* ed. Meredith Minkler. New Brunswick, NJ: Rutgers University Press. (26-51).
- Minkler, M, AP Garcia, V Rubin, and N Wallerstein. 2012. *Community-Based Participatory Research: A Strategy for Building Healthy Communities and Promoting Health Through Policy Change, A Report to the California Endowment*. Berkeley, CA: UC Berkeley School of Public Health.

- Minkler, M, and N Wallerstein. 2008. "Community-Based Participatory Research: From Process to Outcomes." San Francisco, CA: Jossey-Bess.
- Morgan, Kimberly J, and Andrea Louise Campbell. 2011. *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy*. Oxford, UK: Oxford University Press.
- Morgen, Sandra. 2002. *Into our Own Hands: The Women's Health Movement in the United States, 1969-1990*. New Brunswick, NJ: Rutgers University Press.
- Moskowitz, Eva S. 2001. *In Therapy We Trust: America's Obsession with Self-fulfillment*. Baltimore, MD: Johns Hopkins University Press.
- Moynihan, Daniel Patrick. 1965. "Negro family: The Case for National Action (A Report for the U.S Department of Labor, Office of Policy Planning and Research)." *Washington, DC: Government Printing Office*. Retrieved September 10:2008.
- Murray, Charles. 1993. "The Coming White Underclass." *Wall Street Journal* October 29: A14.
- Murray, Charles A. 1984. *Losing Ground: American Social Policy, 1950-1980*. New York: BasicBooks.
- Nolan Jr, James L. 1998. *The Therapeutic State: Justifying Government at Century's End*. New York: NYU Press.
- NM SB365 | 2013 | Regular Session." March 15, 2013 *LegiScan*. Accessed July 12, 2016. <https://legiscan.com/NM/bill/SB365/2013>.
- O'Connor, Alice. 2002. *Poverty Knowledge: Social Science, Social Policy, and the Poor in Twentieth-Century US History*. Princeton, NJ: Princeton University Press.
- Olds, David L. 2006. "The Nurse-Family Partnership: An Evidence-Based Preventive Intervention." *Infant Mental Health Journal* 27 (1):5-25.
- Olds, David L, Charles R Henderson, Robert Chamberlin, and Robert Tatelbaum. 1986. "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation." *Pediatrics* 78 (1):65-78.
- Olds, David L, Charles R Henderson, Robert Tatelbaum, and Robert Chamberlin. 1986. "Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation." *Pediatrics* 77 (1):16-28.
- Olds, David L, JoAnn Robinson, Ruth O'Brien, Dennis W Luckey, Lisa M Pettitt, Charles R Henderson, Rosanna K Ng, Karen L Sheff, Jon Korfmacher, and Susan Hiatt. 2002. "Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial." *Pediatrics* 110 (3):486-496.
- Orloff, Ann. 1996. "Gender in the Welfare State." *Annual Review of Sociology* 22:51-78.
- Orr, Larry L. 1976. "Income Transfers as a Public Good: An Application to AFDC." *The American Economic Review* 66 (3):359-371.
- Ostrom, Vincent, Robert L Bish, and Elinor Ostrom. 1988. *Local Government in the United States*. Ithaca, NY: Ics Press.

- Paris, Ruth, Rendelle E Bolton, and M Katherine Weinberg. 2009. "Postpartum Depression, Suicidality, and Mother-Infant Interactions." *Archives of Women's Mental Health* 12 (5):309-321.
- Patterson, Orlando. 1998. *The Ordeal of Integration: Progress and Resentment in America's Racial Crisis*. New York: Basic Civitas.
- Peck, Jamie. 2001. *Workfare States*. New York: Guilford
- Peterson, Iver. 1995. "Abortions up Slightly for Welfare Mothers." *New York Times*. May 17, 1995.
- Pierson, P. 1993. "When Effect Becomes Cause: Policy Feedback and Political Change." *World Politics* 45(4): 595-628.
- Pierson, Paul. 2000. "Increasing Returns, Path Dependence, and the Study of Politics." *American Political Science Review* 94 (2):251-267.
- Pierson, Paul. 2004. *Politics In Time: History, Institutions, and Social Analysis*. Princeton, NJ: Princeton University Press.
- Pies Cheri, Padmini Parthasarath, Milton Kotelchuck M, and Michael Lu. 2009. "Making a Paradigm Shift in Maternal and Child Health: A Report on the National MCH Life Course Meeting." Martinez, CA: Contra Costa Health Services.
- Piven, F. 2006. *Challenging Authority: How Ordinary People Change America*. Landham, MD: Rowman & Littlefield Publishers.
- Piven, Frances Fox, and Richard A Cloward. 1993. *Regulating the Poor: The Functions of Public Welfare*. New York: Vintage.
- Plotnick, Robert D, and Richard F Winters. 1985. "A Politico-Economic Theory of Income Redistribution." *American Political Science Review* 79 (02):458-473.
- Provence, S. and R. C. Lipton 1963. *Infants in Institutions: A Comparison of Their Development with Family-Reared Infants During the First Year of Life*. Madison, CT: International Universities Press.
- Pykett, Jessica. 2012. "The New Maternal State: The Gendered Politics of Governing through Behaviour Change." *Antipode* 44 (1): 217-238.
- Quandango, Jill S. 1994. *The Color of Welfare: How Racism Undermined the War on Poverty*. Oxford, UK: Oxford University Press.
- Raphael, Dennis. 2008. "Getting Serious About the Social Determinants of Health: New Directions for Public Health Workers." *Promotion & Education* 15 (3):15-20.
- Richmond, Mary Ellen. 1903. *Friendly Visiting Among the Poor: A Handbook for Charity Workers*. London, UK: Macmillan.
- Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Vintage Books.
- Robertson, Ann, and Meredith Minkler. 1994. "New Health Promotion Movement: A Critical Examination." *Health Education & Behavior* 21 (3):295-312.

- Roh, Jongho, and Donald P Haider-Markel. 2003. "All Politics is Not Local: National Forces in State Abortion Initiatives." *Social Science Quarterly* 84 (1):15-31.
- Rohlfing, Ingo. 2013. "Comparative Hypothesis Testing Via Process Tracing." *Sociological Methods and Research* 43: 606-642.
- Rose, Nikolas. 1996. "Governing "Advanced" Liberal Democracies." In *The Anthropology of the State: A Reader*, eds. Aradhana Sharma and Akhil Gupta. Malden, MA: Blackwell Publishing. (144-162).
- Rose, Nikolas. 1999. *Powers of Freedom: Reframing Political Thought*. Cambridge, UK: Cambridge University Press.
- Sabatier, Paul and Hank Jenkins-Smith. 1993. *Policy Change and Learning: An Advocacy Coalition Approach*. Boulder, CO: Westview Press.
- Sabatier, Paul, and Chris Weible. 2007. "The Advocacy Coalition Framework: Foundations, Evolution, and Ongoing Research." In *Theories of the Policy Process*, eds. Paul Sabatier and Christopher Weible. Boulder, CO: Westview Press. (183-224).
- Sampson, Robert J. 2009. "Disparity and Diversity in the Contemporary City: Social (dis) Order Revisited." *The British Journal of Sociology* 60 (1):1-31.
- Sampson, Robert J, and Stephen W Raudenbush. 2004. "Seeing Disorder: Neighborhood Stigma and the Social Construction of 'Broken Windows'." *Social Psychology Quarterly* 67 (4):319-342.
- Schatz, Edward. 2013. *Political Ethnography: What Immersion Contributes to the Study of Power*. Chicago: University of Chicago Press.
- Schensul, Jean J. 2005. "Sustainability in HIV Prevention Research." In *Community Interventions and AIDS*, eds. Edison J Trickett and Wille Pequegnat. New York: Oxford University Press. (176-195).
- Schmidt, Vivien. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11: 303-326.
- Schneider, Anne, and Helen Ingram. 1993. "Social Construction of Target Populations: Implications for Politics and Policy." *American Political Science Review* 87 (2):334-347.
- Schneider, Anne L, and Helen M Ingram. 2005. *Deserving and Entitled: Social Constructions and Public Policy*. Albany, NY: SUNY Press.
- Schram, Sanford. 1995. *Words of Welfare: The Poverty of Social Science and the Social Science of Poverty*, Minneapolis: University of Minnesota Press.
- Schram, Sanford. 2000. *After Welfare: The Culture of Postindustrial Social Policy*. New York: NYU Press.
- Schram, S, Joe Soss, and Richard Fording eds. 2010. *Race and the Politics of Welfare Reform*. Minneapolis: University of Michigan Press.

- Sealander, Judith. 1997. *Private Wealth and Public Life: Foundation Philanthropy and the Reshaping of American Social Policy from the Progressive Era to the New Deal*. Baltimore, MD: JHU Press.
- Seidman, Steven. 2013. "State and Class Politics in the Making of a Culture of Intimacy." In *Intimacies. A new world of relational life*, eds. Alan Frank, Patricia Clough, and Steven Seidman. Oxford, UK: Routledge. 13-29.
- Sen, A. 1999. *Commodities and Capabilities*. Oxford, UK: Oxford University Press India
- Shank, Gary D. 2006. *Qualitative Research: A Personal Skills Approach*. Upper Saddle River, NJ: Pearson Merrill Prentice Hall.
- Shapiro, V, E Adelson, and B Tableman. 1982. "The Introduction of Infant Mental Health Services in Michigan." *Infant Mental Health Journal* 3:69-141.
- Shipan, Charles R, and Craig Volden. 2008. "The Mechanisms of Policy Diffusion." *American Journal of Political Science* 52 (4):840-857.
- Shonkoff, Jack P, and Philip A Fisher. 2013. "Rethinking Evidence-Based Practice and Two-Generation Programs to Create the Future of Early Childhood Policy." *Development and Psychopathology* 25 (4pt2):1635-1653.
- Shonkoff, Jack P. 2009. "The Road to a New Energy System: Mobilizing Science to Revitalize Early Childhood Policy." *Issues in Science and Technology* 26 (1).
- Shonkoff, Jack P, and Samuel J Meisels. 1990. "Early Childhood Intervention: The Evolution of a Concept." In *Handbook of Early Childhood Intervention*, eds. Jack P Shonkoff and Samuel J Meisels. Cambridge, UK: Cambridge University Press. (3-31).
- Shonkoff, Jack P, and Deborah A Phillips. 2000. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press.
- Simmons, Beth A, Frank Dobbin, and Geoffrey Garrett. 2006. "Introduction: The International Diffusion of Liberalism." *International Organization* 60 (4):781-810.
- Simmons, Beth A, Frank Dobbin, and Geoffrey Garrett. 2007. "The Global Diffusion of Public Policies: Social Construction, Coercion, Competition or Learning?" *Annual Review of Sociology* 33:449-472.
- Skocpol, Theda. 1992. *Protecting Mothers and Soldiers: The Political Origins of Social Policy in the United States*. Cambridge, UK: Belknap Harvard.
- Skocpol, T, et al. 1993. "Women's Associations and the Enactment of Mothers' Pensions in the United States." *American Political Science Review* 87(3): 686-701.
- Skocpol, Theda. 2003. *Diminishing Democracy*. Norman, OK: University of Oklahoma Press.
- Smith, Anna Marie. 2007. *Welfare Reform and Sexual Regulation*. Cambridge, UK: Cambridge University Press.

- Smock, Kristina. 2004. *Democracy in Action: Community Organizing and Urban Change*. New York: Columbia University Press.
- Soss, Joe. 1999. "Lessons of Welfare: Policy Design, Political Learning, and Political Action." *American Political Science Review* 93 (2):363-380.
- Soss, Joe. 2002. *Unwanted Claims: The Politics of Participation in the U.S. Welfare System*. Ann Arbor, MI: University of Michigan Press.
- Soss, Joe, Richard C Fording, and Sanford Schram. 2011. *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. Chicago: University of Chicago Press.
- Soss, Joe, Jacob S Hacker, and Suzanne Mettler. 2007. *Remaking America: Democracy and Public Policy in and Age of Inequality*. New York: Russell Sage Foundation.
- Soss, Joe, Richard Fording, and Sanford Schram. 2008. "The Color of Devolution: Race, Federalism, and the Politics of Social Control." *American Journal of Political Science* 52 (3): 536-553.
- Soss, Joe, Sanford F Schram, Thomas P Vartanian, and Erin O'Brien. 2001. "Setting the Terms of Relief: Explaining State Policy Choices in the Devolution Revolution." *American Journal of Political Science* 45 (2):378-395.
- Soule, S, and S Olzak 2004. "When do Movements Matter? The politics of Contingency and the Equal Rights Amendment." *American Sociological Review* 69 (4):473-497.
- Sparling, Joseph, Isabelle Lewis, Craig T Ramey, Barbara H Wasik, Donna M Bryant, and Lisa M LaVange. 1991. "Partners A Curriculum to Help Premature, Low Birthweight Infants Get Off to a Good Start." *Topics in Early Childhood Special Education* 11 (1):36-55.
- Spitz, Rene A. 1945. "Hospitalism; An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood." *The Psychoanalytic Study of the Child* 1:53-74.
- Steinmo, Sven, and Kathleen Thelen. 1992. *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge, UK: Cambridge University Press.
- Stoecker, Randy. 1997. "The CDC Model of Urban Redevelopment: A Critique and an Alternative." *Journal of Urban Affairs* 19 (1):1-22.
- Stoecker, Randy. 2003. "Understanding the Development-Organizing Dialectic." *Journal of Urban Affairs* 25 (4):493-512.
- Stoecker, Randy. 2004. "The Mystery of the Missing Social Capital and the Ghost of Social Structure: Why Community Development Can't Win." In *Community-Based Organizations: The Intersection of Social Capital and Local Context in Contemporary Urban Society*, ed. Robert Mark Sullivan. Detroit: Wayne State University Press. (53-66).
- Stone, Deborah. 2002. *Policy Paradox: The Art of Political Decision Making, Revised Edition*. New York: WW Norton and Company.

- Suttles, Gerald and Mayer Zald. 1985. *The Challenge of Social Control and Institution Building in Modern Society*. Norwood, NJ: Albex Publishing Corporation.
- Tarrow, Sidney G, and J Tollefson. 1994. *Power in Movement: Social Movements, Collective Action and Politics*. Cambridge, UK: Cambridge University Press.
- Thaler, Richard and Cass Sunstein. 2009. *Nudge: Improving Decisions About Health and Wealth*. London: Penguin Books.
- Thelen, Kathleen. 1999. "Historical Institutionalism in Comparative Politics." *Annual Review of Political Science* 2(1): 369-404.
- Thelen, Kathleen. 2002. "The Explanatory Power of Historical Institutionalism." In *Akteure-Mechanismen-Modelle. Zur Theoriefähigkeit makro-sozialer Analysen*, ed. Renate Mayntz. Frankfurt: Campus Fachbuch. (91-107).
- Thelen, Kathleen. 2004. *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States, and Japan*. Cambridge: Cambridge University Press.
- Thompson, Lisa, Vickie Kropenske, Christoph M Heinicke, Deanna S Gomby, and Neal Halfon. 2001. "Home Visiting: A Service Strategy to Deliver Proposition 10 Results. Building Community Systems for Young Children." Report. California University, Los Angeles. Center for Healthier Children, Families and Communities. 1-59.
- Trickett, Edison J. 2009. "Multilevel Community-Based Culturally Situated Interventions and Community Impact: An Ecological Perspective." *American Journal of Community Psychology* 43 (3-4):257-266.
- Trickett, Edison J. 2011. "Community-Based Participatory Research as Worldview or Instrumental Strategy: Is it Lost in Translation(al) Research?" *American Journal of Public Health* 101 (8):1353-1355.
- Trickett, Edison J, and Sarah Beehler. 2013. "The Ecology of Multilevel Interventions to Reduce Social Inequalities in Health." *American Behavioral Scientist* 57 (8):1227-1246.
- Trickett, Edison J, and Mary Ellen Oliveri. 1997. "Ethnography and Sociocultural Processes: Introductory Comments." *Ethos* 25 (2):146-151.
- U.S. Census Bureau, American Community Survey. 2012. DP03 3-year summary file. <http://factfinder2.census.gov>.
- Volden, Craig. 2006. "States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program." *American Journal of Political Science* 50 (2):294-312.
- Volden, Craig, Michael M Ting, and Daniel P Carpenter. 2008. "A Formal Model of Learning and Policy Diffusion." *American Political Science Review* 102 (3):319-332.
- Wacquant, Loic. 2001. "Deadly Symbiosis when Ghetto and Prison Meet and Mesh." *Punishment & Society* 3 (1):95-133.

- Wacquant, Loïc. 2007. "Territorial Stigmatization in the Age of Advanced Marginality." *Thesis Eleven* 91 (1):66-77.
- Wacquant, Loïc. 2008. *Urban Outcasts: A Comparative Sociology of Advanced Marginality*. Cambridge, UK: Polity.
- Wacquant, Loïc. 2009. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham, NC: Duke University Press.
- Wacquant, Loïc. 2010. "Crafting the Neoliberal State: Workfare, Prisonfare, and Social Insecurity." *Sociological Forum* 25 (2):197-220.
- Waldner, David. 2012. "Process Tracing and Causal Mechanisms." Paper presented at the Institute for Qualitative and Multi-Method Research, Syracuse University.
- Walker, Robert. 1999. "'Welfare to Work' Versus Poverty and Family Change: Policy Lessons from the U.S.A." *Work, Employment and Society* 13 (3):539-553.
- Wallerstein, Nina. 2006. "The Effectiveness of Empowerment Strategies to Improve Health." Health Evidence Network. Copenhagen: World Health Organization.
- Weatherston, Deborah J 2001. "Infant Mental Health: A Review of Relevant Literature." *Psychoanalytic Social Work* 8 (1):43-74.
- Weatherston, Deborah J, Melissa Kaplan-Estrin, and Sheryl Goldberg. 2009. "Strengthening and Recognizing Knowledge, Skills, and Reflective Practice: The Michigan Association for Infant Mental Health Competency Guidelines and Endorsement Process." *Infant Mental Health Journal* 30 (6): 648-663.
- Weatherston, Deborah J, and Carla Barron, 2009. "Reflective Supervision" Australian Association for Infant Mental Health. <http://www.aaimhi.org/resources/reflective-supervision/>
- Weible, Christopher M, Paul A Sabatier, and Kelly McQueen. 2009. "Themes and Variations: Taking Stock of the Advocacy Coalition Framework." *Policy Studies Journal* 37 (1):121-140.
- Weir, Margaret, Ann Shola Orloff, and Theda Skocpol. 1988. *The Politics of Social Policy in the United States*. London, UK: Routledge Taylor & Francis.
- Weiss, H, and Lisa Klein. 2007. *Changing the Conversation about Home Visiting: Scaling up with Quality*. Paper. Harvard Family Research Project.
- Weldon, S Laurel. 2006. "The Structure of Intersectionality: A Comparative Politics of Gender." *Politics & Gender* 2 (2):235-248.
- Weldon, S Laurel. 2006. "Women's Movements, Identity Politics, and Policy Impacts: A Study of Policies on Violence Against Women in the 50 United States." *Political Research Quarterly* 59 (1):111-122.
- White, Julie Anne. 2000. *Democracy, Justice, and the Welfare State*. University Park. PA: Pennsylvania State University Press.

- Wieder, Serena. 1994. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Diagnostic Classification: 0-3*. Arlington, VA: Zero to Three.
- Wilcox, John T. 1989. "Nature as Demonic in Thomson's Defense of Abortion." *The New Scholasticism* 63 (4):463-484.
- Will JA. 1993. "The Dimensions of Poverty: Public Perceptions of The Deserving Poor." *Social Science Research* 22 (3):312-332.
- Wilson, James Q. 1997. "Paternalism, Democracy, and Bureaucracy." In *The New Paternalism: Supervisory Approaches to Poverty*, ed. Lawrence M Mead. Washington, DC: Brookings Institution Press. (330-344).
- Wolin, Sheldon. 2008. *Democracy Incorporated: Managed Democracy and the Spector of Inverted Totalitarianism*. Boulder, CO: Westview.
- World Health Organization. 2000. "A Life Course Approach to Health." http://www.who.int/ageing/publications/lifecourse/alc_lifecourse_training_en.pdf.
- Wright, Gerald C. 1977. "Racism and Welfare Policy in America." *Social Science Quarterly* 57 (4):718-730.
- Yanow, Dvora. 1996. *How Does a Policy Mean? Interpreting Policy and Organizational Actions*. Washington, DC: Georgetown University Press.
- Young, Iris Marion. 2005. "The Logic of Masculinist Protection: Reflections on the Current Security State." In *Women and Citizenship*, ed. Marilyn Friedman. New York: Oxford University Press.
- Zeanah, Charles H., ed. 2009. *Handbook of Infant Mental Health*. Guilford Press.
- Zeanah, Charles H, and Paula Doyle Zeanah. 2009. "The Scope of Infant Mental Health." In *The Handbook of Infant Mental Health*, ed. Charles H Zeanah. New York: Guilford Press. (5-21).
- Zylan, Yvonne, and Sarah A Soule. 2000. "Ending Welfare as we Know it (again): Welfare State Retrenchment, 1989–1995." *Social Forces* 79 (2):623-652.