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Searching for ´the usual suspects´: The role of discretion and target group constructions in the frontline of policy implementation

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Introduction

How policy is implemented, and what role the frontline workers play in the implementation process have been investigated in several studies. A central focus in the literature as well as in the general debate has been to understand why implementation of policies fail and how policy is altered or adjusted during the implementation process (Caswell et al. 2017, Hupe, Hill & Buffat 2015, Hill & Hupe 2002, Barret 2004). An important lesson from the literature is that analysing the formal policy (e.g. content, aim and design) only gives a partial understanding of how and why the final product – the policy that the citizens or clients meet – takes particular forms. Especially when it comes to understanding why policy is not implemented in practice, studies of the formal policy in many cases do not provide us with answers (Caswell et al. 2017, Brodkin 2017). The implementation literature emphasize that *how* policies are implemented can have an even stronger impact on the outcome than the actual content of the policy (Zacka 2015; Rothstein 2009). Thus to better understand how and why policy outcome takes particular forms one needs to investigate how the policy is transformed from policy to everyday practice in the frontline. In this light to fully understand and analyse policies one needs to start by investigating the policy in the form it takes when it is

delivered to the client, because *"public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators. These decision-making arenas are important, of course, but they do not represent the complete picture. To the mix of places where policies are made, one must add the crowded offices and daily encounters of street-level workers." (Lipsky 1980/2010, p. xiii)* Building this perspective several studies have instigated this topic emphasizing how frontline workers play a central role in implementation and policy-making as their judgement and priorities, their exercise of discretion, when 'doing' policy influence how the policy is delivered to the citizen. Though frontline workers do not invent the policy, their actions shape and transform it into practice (Lipsky 2010; Brodkin 2012; Jørgensen et al 2015; Zacka 2017; Cohen & Aviram 2021). Many of the studies "point to the limitations of seeking to explain street-level behavior as a consequence of individual level phenomena (e.g. preferences, training etc.) without accounting for organizational conditions that affect what individuals can and are likely to do under certain conditions" (Brodkin 2015:25-42).

This can for instance be by expanding or limiting the discretion or through particular organizational setups, which increase various coping mechanisms including stereotyping and other categorizations of clients. The studies point out that organizational factors such as technologies and management strategies (e.g. new public management) alongside organizational structures influence and steer the implementation or outcome of policy by limiting the discretion and autonomy of the frontline workers (McGann et al 2020, Evans 2011, Lipsky 2010, Caswell et al 2017).

The studies emphasize that discretion is exercised within organizational and legal boundaries and that frontline workers therefore do not freely do what they wish, rather they do what is possible within the particular context (Brodkin 2015). In this light, the studies also illustrate how tension and moral dilemmas in frontline increase when these boundaries are narrowed through excessive and detailed steering - in many cases with negative consequences not only for the work life of frontline

workers but also for the client or the policy implementation (Brodkin 2017, 2011; Zacka 2017; Adler 2013; Hasenfeld 2010). Following this, the majority of studies rightly problematize the effects of limiting the discretion and autonomy of the frontline workers and illustrates how various coping mechanisms increase as a response to the intensified steering. However, the majority of literature addresses coping mechanisms in situations where discretions is reduced or even suspended. What happens in the opposite situation, where discretion is maintained or even expanded is not given the same attention, but it is indirectly assumed that expanding autonomy and discretion automatically will improve policy delivery.

However, our case illustrates that it is more complex than that. We have investigated the opposite case: a case where the problem is not a lack of discretion and autonomy, rather it is the lack of organizational boundaries to shape the discretion and the absence of professional operationalization of the policy, that becomes the problem.

The aim of our study is to investigate the implementation of a new policy to prevent and detect vulnerability in children. More specifically we analyse how frontline workers working with vulnerable children assign meaning to the core concepts of the policy and how they in this light categorize their clients.

We identify a case where the policy is highly ambiguous, the definitions of target groups, core concepts or central goals are vague and the general steering of the frontline is not characterized by strong elements of limitations of the discretion. We argue that in this case the policy making role of the frontline is in fact expanded as the frontline workers as a result of the vague policy and broad organizational boundaries end up affecting not only how the policy is delivered but also to a large degree who the policy targets and what problems it aims to solve. The result in our case is not an increased professionalism or an improved practice. Rather it is organisational inertia as the frontline workers continue their already established practice. As a result the policy goals of improved

prevention of vulnerability and more efficient earlier detection of vulnerable children is not implemented regardless of general support for the policy among frontline leaders and frontline workers. In this way, the case contributes with insights on consequences of lacking operationalisation and clarification of core concepts of a policy during implementation. It is an illustrative case of how policies are often implemented into frontline practice, but also of why this approach is not sufficient.

Case: The preventive social policy in a large Danish municipality, 2016-2019

This article investigates the implementation of a preventive social policy in one of the largest Danish municipalities over a four years period from 2016 to 2019. The aim of the policy is to prevent children and youth from becoming vulnerable and developing more serious social problems. A core element in the policy is to identify the group of children who are at risk of developing problems at an early stage where the potential problems can be prevented. The policy includes a number of specific changes and goals which should help identifying the children at risk at much earlier stages. This includes placing a social worker from social service in the schools and emphasizing that as a first priority interventions targeting vulnerable children should be organized within the ordinary schools and day care institutions rather than by the social service.

Social work with children and youth in Denmark has traditionally focused on helping the children already facing severe problems. In a social work context, this is a well-known target group. However, the preventive social policy introduces a new and less clear defined target group: the children and youth at risk of developing problems who are not necessarily already known to social services. Hence, focus is on strengthening early prevention by doing something new to a potentially new target group rather than doing more of the same towards children already known to the social

system. This means that in order fully to implement the policy the frontline workers must expand their target group by including a new group of children in their practice.

Preventive policy strategies

The social policy, of which we investigate the implementation, is a local policy developed by the municipality but highly inspired by an internationally increased focus on preventive policy strategies (Clark 2015). These preventive strategies are to detect and tackle risk factors as early as possible and before they develop into severe social problems that are both harmful for children's current wellbeing and have effects on later development. Theoretically, preventive policy strategies draw on a distinction between primary, secondary and tertiary prevention (Simeonsson 1991, Caplan and Grunebaum 1967). This three-layered distinction is based on the recognition that treating only already known cases of failure to thrive will not adequately reduce the share of children who experience vulnerability and social problems. Hence, the premise of layering preventive initiatives is that a focus on all three layers can prevent manifestation, severity and developmental delay of a given social problem. The three types of prevention have different target groups and aims. Primary prevention aims to reduce the number of new cases of children who fail to thrive. Thus, it often targets large populations of seemly thriving children. Secondary prevention aims to prevent social problems among groups of children exposed to already known risk factors by compensating for these risk factors if possible. Tertiary prevention aims to reduce manifest and severe social problems and prevent further problems to occur (Simeonsson 1991).

Organisational context and implementation activities

The policy is developed in collaboration between two public administrations within the municipality; The School administration and The Family and Employment administration, both of which in a Danish context employs a very large number of frontline workers. The school

administration includes 50 public schools, 5 schools for children with special needs, a unit for pedagogical and psychological counselling, and a unit for youth counselling. The school administration employs 3000 employees and the primary professions are; teachers, kindergarten teachers, psychologists, and a number of frontline leaders. The Family and Employment administration includes units of day-care in private homes, day-care in nurseries and kindergartens, dentistry, health care, a centre for interdisciplinary prevention, a centre for children, young people and families and a centre for social affairs. The Family and Employment administration employs 3200 employees and the primary professions are; kindergarten teachers, kindergarten assistants, nursery nurses, social workers, health care workers and a number of frontline leaders.

The target groups described within the local policy fit the target groups of primary, secondary and tertiary prevention. Previously the task of helping vulnerable children has been located with the social service and the social workers employed here. However, the collaboration between the two administrations is to strengthen interdisciplinarity and promote focus on early detection and prevention by including also professionals working with all children By doing so the aim was to include other target groups in the preventive work as well as strengthening the focus om primary and secondary prevention.

The policy was given much attention in the municipality and when it was adopted a large introductory conference was held to mark the policy and inform practitioners. The policy was considered an investment in the future and the idea was that by prioritizing and strengthening the preventive work now fewer children would become vulnerable and in need of help in the future.

During the four-year period, a number of implementation activities were planned and carried out within the municipality. These included formal information material on the content of the policy,

workshops, and production and distribution of material about the policy such as posters and postcards with pictures and relevant information about the policy to the different groups of frontline workers. During the period the frontline leaders where encouraged to distribute information and facilitate discussions of the policy within their team of employees. Hence, much attention was given to disseminate information about the policy throughout the organisation. However, the information materials focused on the aim of the policy in overall terms and did not operationalise and assign meaning to exactly what needed to change and for whom.

Hypothesis

Despite knowledge of - and support for - the new policy at an overall level, we posit that an implementation of the policy into practice, in this case a greater focus on primary and secondary prevention, requires distinct operationalisation of core concepts of the policy and how it differs from the existing practice. This is especially likely to be the case in organisations without strong organisational boundaries as the implementation otherwise comes to depend greatly on the frontline workers' operationalisation capacities at an individual level. This leads to the following two hypothesis:

> H1: At an overall level the frontline workers support the stronger emphasis on early prevention and include all three layers of prevention in their practice.
>
> H2: Because of a low degree of operationalization of the core policy concepts little change can be observed when it comes to frontline workers' identification of target groups and focus on early prevention.

Research design, data and methods

The case study consists of two surveys among the frontline workers and the frontline leaders in both administrations as well as interviews with in total 90 frontline workers and frontline leaders, consisting of 16 individual interviews with frontline workers, 11 group interviews using vignette method and six group interviews with frontline leaders conducted over a 3 year period.

The analysis in this article is based on the results from the surveys. The two surveys are conducted respectively 8 and 30 month into the implementation process. The first point of measure was at 8 month as it allowed time for information about the new policy to disseminate throughout the municipality. The second point of measure was at 30 month so that there was room for changes since the first point and still time to analyse data within the project period. Both surveys are cross sectional surveys distributed to 50 % of the frontline workers in the two administrations as well as to all frontline leaders in both administrations (in total 403 frontline leaders). The leaders are organizationally placed in the frontline such as team leaders and practice leaders in daycare institutions or schools. In total, 3098 persons received the survey 1 and 58 % or 1796 persons responded. Survey 2 was distributed to 3503 persons and 55 % or 1927 persons responded.

The surveys measure how the respondents understand the core concepts of the policy, their perception of various risk factors that children and youth can be exposed to as well as the respondents' perceptions of symptoms indicating vulnerability. The statistical analysis then investigates how perceptions of risk factors and symptoms are associated and how specific target groups are defined based on these associations.

Variable description and methods used

The surveys measure the overall understanding of some of the core concepts of the policy such as "prevention" and "early detection". The perception of symptoms and risk factors, and by that the

target group, are measured in two ways. Initially we ask the respondents to describe when they consider a child in risk of becoming vulnerable and developing special needs. This variable is an open question with no maximum of words. The purpose is to capture the immediate understanding among the respondents of which children they see as target groups for preventive social policy.

In the analysis, the open question variable is re-coded into ten broad categories:

- Socially marginalized families (such as neglect, violence, abuse, substance abuse or mental illness among the parents)
- Poverty
- Disabilities (including mental illnesses and disorders)
- Learning issues
- Children who are showing signs of not thriving (e.g. loneliness, social isolation or conflicts or psycho-social symptoms)
- Acute strain (e.g. divorce, death in the family)
- Children with poor health
- Bi-lingual children (immigrants)
- Other parental issues (e.g. parents are too busy with career, parents are pushing too much for performance in school etc.)
- Other issues (e.g. prematurely born children)

After the open question, two large collections of variables measuring potential risk factors and potential symptoms (so called test-batteries) follow to investigate further, which children are considered the target group of the policy. The batteries measure respectively 16 potential risk factors and 13 potential symptoms of vulnerability. The respondents are asked to rank each risk factor or symptom on a scale ranging from 1 to 10 in accordance to how big a risk or how alarming a symptom is. The risk factors and symptoms are constructed based on the existing knowledge and literature on vulnerable children and youth.

In order to investigate how the frontline workers associate the potential symptoms they observe in the children with the potential risk factors around the child two non-recursive structural equation models (SEM) are constructed based on data from each of the two surveys. SEM are useful tools for

analysing complex patterns of relationships between multiple variables within a single model as it allows complex multiple regression analysis, including multiple mediating effects and using latent variables (Kline 2011). In this analysis we apply a model build approach, whereby the predictors are added hierarchically to the model according to theoretical importance (Kline 2011).

We use the models to test whether or not some risk factors or characteristics are perceived as more closely associated to initial symptoms of vulnerability than others are and if this perception changes during the implementation period. In this sense, the models analyse how frontline workers perceive the causal connections between potential risks and the observed symptoms in the child. In other words, *who* and *what* they look for when identifying children in need of early detection or prevention.

The first SEM tests how perceptions of risk factors are associated to what we call "social symptoms" of vulnerability, while the second model tests how perceptions of risk factors are associated to what we call "behavioural symptoms" of vulnerability. Both models are run on each of the two surveys. The two models are overall similar and consist of a number of observed variables and a number of latent variables measuring "socially marginalised families" and "disability", elaborated on below, as well as the dependent variables "social vulnerability" and "behavioural vulnerability", respectively in model 1 and 2 (figure 4 and 5).

Socially marginalized families

Based on the findings in the open question variable as well as the qualitative findings in the study, in both SEM the independent variable is a latent variable named "Socially marginalized families". The latent variable measures the risk factors related to traditional social problems found in marginalized families. In the analysis this variable is constructed using four interval-scaled single items that each captures one type of social problems:

- Substance abuse in the family (drugs, medicine, alcohol)
- At least one of the parents have a mental illness
- Suspicion of domestic violence within the family
- Placement in foster care

In both surveys all four items have factor loadings above 0.6 and are loading sufficiently on the underlying factor "socially marginalized families" (see appendix A1 and A2) (Kline 2011).

In our analysis, the item measuring financial hardship as a risk factor does not load sufficiently enough on the underlying "Socially marginalized families" factor, and is therefore not included in the latent variable, but placed as a manifest variable in the models. Recent Scandinavian qualitative studies also point to the fact, that frontline workers do not consider financial hardship a social problem that should be addressed in the same way as other traditional social problems associated with marginalized families (Nørup & Jacobsen 2021).

Disability

Both models have several intervening variables, that all measure other potential risk factors. One of the intervening variables is a latent variable named "Disability", and measures the perception of disability as a risk factor. As disability is a complex phenomenon that both includes physical disabilities, mental disorders, cognitive disabilities as well as learning disabilities, measuring disability using just one question would not have been a valid measure, as we would not have known which type of disability the respondents were basing their answers on. Instead we use four different measurements of disability as a risk factor and construct a latent variable. In both surveys the factor loadings for all four items are above 0.6 (see appendix A1 and A2).

Other intervening variables

Beside disability, both models also include four single items that measure other potential risk factors. Based on the results from the qualitative part of the study, we hypothesise that these factors

are mediating variables in the models. Rather than playing an independent role, they are by the frontline workers seen as additional risk factors for children already at risk because of existing problems within their immediate environment. We have therefore placed these items as well as the latent disability variable as mediating variables. In this way, we can measure both the variables' individual correlation with the dependent variable (the direct effect) as well as test our hypothesis that these factors primarily are considered to represent a risk to children growing up in families with already existing social problems.

The four risk factors are:

- Financial hardship
- Incidents causing acute strain on the family (divorce, death, serious illness)
- Bullying
- Lack of parental participation (e.g. in school activities, meetings, social activities etc.)

Social symptoms (dependent variable model 1)

The dependent variable of model 1 is a latent variable measuring social symptoms of vulnerability. The latent variable is measured using five social symptoms. These are symptoms of a child being vulnerable that manifest themselves in social situations regardless of what they are caused by. The five symptoms are:

- Difficulties with social relations (e.g. play, group work, friendship)
- Isolation or loneliness
- Absence from social activities (e.g. leisure time sports, birthday parties, social gatherings or activities)
- Changes in social relations (e.g. isolation, mood swings, sadness)
- Difficulties with "youth life" (e.g. troubles navigating in love- and friendship relations, parties etc.)

As shown in figure 4 and 5 all five items have factor loadings above 0.7 and are loading sufficiently on the underlying factor, we have named "social symptoms".

Behavioural symptoms (dependent variable model 2)

The dependent variable of model 2 is a latent variable measuring behavioural symptoms of vulnerability. The latent variable is measured using four behavioural symptoms. These are symptoms of a child being vulnerable that manifest themselves in behavioural patterns regardless of what they are caused by. The four symptoms are:

- Criminal activities or suspicion hereof
- Excessive use of alcohol, drugs or medicine
- School drop-out, absence from school or youth unemployment
- Sexual behavior that attracts attention (e.g. behaving too mature, having troubles setting boundaries etc.)

As shown in figure 6 and 7, all four items have factor loadings above 0.7 and are loading sufficiently on the underlying factor, we have named "behavioural symptoms".

Place of employment

The last variable in the models is a binary variable measuring in which of the two administrations the leader or frontline workers is employed. As the two administrations employ rather different professions, which could have different professional focus and cultures, the variable is used as a control variable.

Findings

H1 posits that, the majority of frontline workers support the stronger emphasis on early prevention and include all layers of prevention in their definitions of preventive work. The initial findings support this hypothesis. In the first survey, the respondents are asked if they support the intentions of a stronger focus on prevention and early detection in the policy. 84 % of the respondents reply that they highly agree with these intentions, and 82 % reply that there is a need for further

improving the frontline practice when it comes to prevention and early detection. This shows very high initial support for the intentions in the policy.

In both surveys, the respondents are asked what they primarily understand by the word "prevention". In accordance to the three-layered structure of the social policy (Simeonsson 1991), the respondent are given three options to choose from. These are broad interventions targeting all children such as health campaign (primary prevention), interventions targeting children exposed to already known risk factors such as extra language training of children with immigrant background (secondary prevention) or interventions aiming at reducing existing social problems among the most vulnerable children e.g. children in foster care (tertiary prevention).

The descriptive results in figure 1 show, that the respondents' answers are almost equally divided between the three categories and little change can be observed throughout the implementation period.

Figure 1 around here

Looking at the answers for the three large groups of frontline workers the picture is the same, indicating that different professional backgrounds do not cause divided responses.

Figure 2 around here

These initial findings express a broad focus on all three layers of prevention with almost equal distribution within each layer. Hence, at an overall theoretical level the respondents, regardless of professional background, understand and support the policy's aim of three-layered prevention, emphasizing early detection and prevention.

However, when the respondents are asked to operationalise whom they consider the target group for prevention, the pattern changes towards a skewed focus on already known cases within the social system (figure 3). A large majority in both surveys identifies children growing up in socially marginalised families facing already known problems such as neglect, violence, substance abuse, mental illness or unemployment among the parents as a target group.

The remaining risk factors are mentioned much less frequent . As the categories are recoded categories from an open, qualitative variable where the respondents were allowed to mention more than one situation, the percentage do not sum up to 100 %. Here we also observe very little change in who the respondents define as the target group for the policy, when comparing the answers from the two surveys.

From a qualitative perspective, many of the answers also associate socially marginalised families to the remaining risk factors, for instance by expressing that *"Children with learning disabilities are in risk if they grow up in families with social problems and little resources"*.

Figure 3 around here

Figure 3 gives a strong indication that socially marginalised families are the primary focus, also when doing preventive social work and early detection. This finding is very much in line with the results from the qualitative interviews that also revealed a strong focus on marginalised families and on children already known to the social administration (Nørup and Jacobsen 2021).

Thus even though the initial findings show a strong support for the new policy and an equal focus on all three layers of prevention, when it comes to the operationalization of what should be prevented and who should be targeted, the results show a strong and uniform focus on tertiary prevention. This contradicts H1.

Hence, when moving from an overall theoretical perspective on prevention to definitions of the target groups for preventive initiatives, the frontline workers' categorisations and perspectives changes, as they primarily comes to focus on the tertiary layer.

To further investigate how frontline workers associate specific risk factors with observed symptoms in children two SEM are constructed and run on the data from each of the two surveys. The models study the causal chains where various risk factors are linked to each other and to the symptoms of vulnerability in children. Both models are in both surveys found to have sufficient model fit (see table 1 below).

Table 1 around here

The statistical analysis begins with a test of model 1 based on the first survey, shown in figure 4 below. The model analyses the effects of risk factors on social symptoms.

Figure 4 around here

As shown in figure 4, very strong total effects of "socially marginalized families" is found on social symptoms[1].

This strongly indicates that symptoms of social vulnerability is highly associated to families already known to the frontline workers as marginalised families. The association also indicated that dysfunction within these families, ahead of structural factors, health issues or disability, is the primary focus point when addressing potential causes for social symptoms. Furthermore, there is a strong indirect effect of the marginalised families-variable on all the intervening variables. This indicates that the respondents see these risk factors such as disability and lack of parental

[1] For the full statistical output see appendix

participation, but they mainly consider them additional risk factors for children who are already exposed to severe social problems within their families, rather than independent risk factors for all children regardless of family background.

Apart from bullying, which are found to have a moderate total effect on social vulnerability, the remaining risk factors have little or no direct, indirect or total effect on the dependent variable.

The same model is then run on data from the second survey (figure 5). The results show that during the 22 month between the collections of the surveys very little has changed in the frontline workers' perception. The output from the analysis on both surveys are remarkably similar.

*** *Figure 5 around here* ***

In model 2 a similar analysis is conducted, testing the effects on behavioural symptoms of vulnerability. Similar to the analysis of model 1, model 2 is also run twice using data from respectively survey 1 and 2. The model analyses the effects of risk factors on behavioural symptoms. In figure 6 the results from the analysis of the first survey are shown.

*** *Figure 6 around here* ***

The results resemble the results of model 1 as they show strong effects[2] of marginalised families on behavioural symptoms of vulnerability. Similar to model 1, socially marginalized families also has very strong direct effects on all intervening variables, indicating that other risk factors besides growing up in socially marginalised homes are seen either as a product of socially marginalised homes or only as risk factors if the child is already in a socially marginalized environment. Turning the attention to the intervening variables a similar pattern to the pattern of model 1 can be observed. The only intervening variable that has an independent moderate effect is bullying. The

[2] For the full statistical output see appendix

remaining intervening variables are all without effect, and disability and financial hardship is even insignificant.

When the model is run on data from the second survey (see figure 7) a very similar pattern emerges. Very little change can be observed between the models in figure 6 and 7 which further confirms that little change in the frontline workers perception of target groups have happened during the 22 month.

**** Figure 7 around here ****

In all four variations of the model more than 60 % of the variance on the dependent variable is explained by the variables in the model. The models also explain high shares of the variance (between 25 % and 66 %) on all intervening variables which indicates that respectively social and behavioural symptoms of vulnerability is highly associated with children from families already known to be socially marginalised (see appendix A1 and A2).

In all four models no significant difference is found between respondents employed in the social administration and the schooling administration.

Thus, the results of the SEM models highly support H2 as little change can be observed when it comes to defining target groups and thereby operationalizing which type of problems is considered relevant to a preventive effort.

Discussion and conclusion

What is prevented and who is targeted

It is clear when looking at empirical results from the study that the frontline workers in the municipality to a very large degree know and support the preventive policy at an overall level. This

finding is in line with the widespread idea that prevention is important and can function as a tool to reduce the number of vulnerable children. The importance of such initial support or sense of urgency when implementing changes, is emphasized throughout the literature (Kotter 1995, Burnes 2004, Fernandez and Rainey 2006). Our data does not point to notable differences in definitions of prevention between frontline workers of different professional backgrounds, based on job functions or the characteristics of the children they primarily interact with in their everyday practice.

Despite this support, very little change is seen in how frontline workers operationalize and assign meaning to the core concepts of early prevention. When it comes to defining and constructing the target groups for the prevention policy and the children to address in preventive work and early detection, the frontline workers to a large extend address children already facing severe problems in their home environment. The vast majority of the frontline workers identify the children who faces severe social problems and are in need of tertiary prevention.

The skewed focus on children already facing severe social problems does not match the focus on early prevention and detection in the preventive policy. However, the concept of the target groups of early prevention is vaguely defined in the policy, as it emphasizes the importance of prevention rather than elaborating on what should be prevented, how and for whom. The frontline workers are in this case left with a very large room to practice their own individual discretion and define the concepts and target groups of prevention according to their own knowledge and experiences.

The results from the SEM point in the same direction which indicates that the frontline workers in our study, regardless of their professional background or specific job function, to a large extend perceive the symptoms of social and behavioural vulnerability as something that are primarily found among a specific group of children and youth. Furthermore, the model results do not change noticeable in the period between survey 1 and 2. Thus the risk of becoming vulnerable is strongly

associated with children and youth growing up in marginalized families already facing social problems to an extend where the family either already is a case at social services or should be, according to legislation. As a result, the risk of vulnerability is understood as something associated to children and youth already living in so precarious situations that early prevention or detection in most cases is too late.

Despite the ambition to broaden the preventive interventions, the frontline workers sustain a status quo by continuously looking for 'the usual suspects' – the children and youth they already know and identify as vulnerable.Target group construction and policy making

It is well established in the literature on frontline work that frontline workers act as policy makers because their actions shape the form a policy take when it is implemented into practice (Lipsky 2010, Brodkin 2017, Zacka 2017, Hupe & Hill 2007, Cohen & Aviram 2021).

In this sense, frontline workers are agents who become policy makers in the form of operationalizing the intent of the policy into specific and concrete actions and initiatives at the right time for the pre-defined target groups of the policy (Lipsky 2010, Brodkin 2012).
The frontline workers in the municipality we have studied are no exception. They clearly assign meaning to the broad concepts they are meant to implement, and by doing so they shape the policy into particular practises. However, in our study the policy making aspects of frontline work cannot be reduced to decisions of how a policy is delivered to the client, as they have a very large degree of discretion when it comes to implementing the concept of prevention into practice. As a result we see that the frontline workers not only influence *how* the policy is practised. They also influence and shape *who* is being targeted and *what* is being done.

Several studies have shown how frontline workers categorise their clients by dividing them into different categories such as deviants, dependents or deserving (Schneider & Ingram 1993, Schram

et al 2009, Jilke & Tummers 2018 Hupe & Hill 2007; Jilke & Tummers 2018; Maynard-Moody & Mosheno 2003, McGann et al 2020) or in the case of vulnerable children; normal, worrying or at risk (Nørup & Jacobsen 2021, Harrits & Møller 2013). Our findings expand the frontline workers' role as policy makers even further. The core concepts of the frontline workers' implementation are 'prevention' and 'early detection' and the target group is 'children in risk of becoming vulnerable'. These concepts are vaguely defined and without clear boundaries within the policy, and therefore the frontline workers can assign them many different meanings and definitions. This means that in practice, deciding what should be prevented and who should be eligible for preventive interventions lies very much in the frontline organisations and in the hands of the frontline workers. In the case presented here, they end up influencing and defining the content of the policy beyond deciding how it is done and how clients are categorized.

The frontline professionals in this case are professional and well-trained practitioners. In spite of this, the expansion of their policy-making role, in combination with their path-dependency in practice, seems to have as a result that the purpose of the policy is not being implemented, the problems it aims to prevent is not being prevented, and the target group is being left without help.

Even though frontline work is characterized by various degrees of discretion and even though this discretion can be considered a necessity for doing 'people-changing' frontline work (Hasenfeld 2010) the task of defining the target group and the central elements of a policy is typically understood as something that has been done by formal policy makers.

When frontline workers are understood as policy makers it is rarely to the extend of defining policy (e.g. target groups, aims and core concepts). Rather their contribution to policymaking lies in decisions on how the policy is delivered to the pre-defined target groups. Yet what we see in our study is that frontline workers do not only act as policy makers when they decide how a policy is

delivered. They also play a crucial role in defining not just what the clients are (for instance normal or deviant) but also who the target group of a policy is and how the core concepts that are to be implemented should be defined.

Barriers to implementation

The way frontline workers construct and define the target group and the core concepts of the policy – and especially the extent to which these constructions takes place - play a central role in defining not just the outcome but also the content of the policy implemented. The idea of early prevention in the policy we have studied is about detecting the children. The emphasis is on strengthening the primary and secondary prevention in order to do something new rather than doing more of the same.

Yet what happens as this policy meets practice is that frontline workers define early prevention as the ability to detect the often very serious social problems within marginalised families faster or at earlier stages rather than identifying potential risks before actual problems occur or in the initial stages of the problem. In this way, early prevention becomes a tool to identify children and youth in abnormal social situations. It does not on the other hand serve as a tool to prevent everyday problems from turning into something more severe.

This skewed focus does not happen because the frontline workers disagree with the policy or are unwilling to change their way of working, as there is a broad support for the aim of the policy. Neither does the results points to lack of implementation activities. However, what is not included in the policy and the implementation activities is a clear definition of core concepts and target groups and a professional discussion of what prevention means in the local practice of frontline workers. While it is clear that the political aim is to address the risks children are faced with before they develop into serious social problems, it is much less clear which everyday problems or

symptoms should be addressed by the preventive effort in practice. In other words, the boundaries within the policy when it comes to defining whom it could and should be targeting are very broad and ambiguous. Parallel to this, the organizational boundaries found in many other studies such as new public management instruments e.g. management-by-objectives, performance measurements, financial incentives and detailed administrative tools are very few compared to numerous studies of the frontline work within the field of employment policies.

The result seems to be, that the frontline workers turn to the definitions and target groups they already know and for whom various interventions is already developed and implemented. In this light, the frontline workers of our study cope with dilemmas in their practice partly by modifying the goals of the policy by changing the focus from primary and secondary prevention to tertiary prevention, and partly by using a routinized approach to identify the potentially vulnerable children. While these sort of coping mechanisms originally described by Lipsky (2010) are well-known in frontline research, our findings show an often overlooked dimension of the issue.

The majority of the existing literature emphasize how coping mechanism such as routinizing and categorizing clients into simplified categories (e.g. willing or unwilling, deserving or non-deserving) increase when resources are reduced or professional autonomy restrained (Hupe et al 2016; Van Berkel et al. 2017; Schneider & Ingram 1993, Schram et al 2009, Jilke & Tummers 2018). The literature also shows how these limitations in resources and room of manoeuvre affects the relationship with clients and causing situation where the frontline worker is either ”moving towards, away or against clients” (Sætren 2021, p. 1017). But contrary to most studies of frontline work, we do not identify these mechanisms. We do see a strong element of coping, but the coping strategy we identify is that frontline workers stay on their already well-known path rather than adopting the new policy into their practice. They do so not because their discretions is limited and

their resources reduced but because the organizational boundaries are too broad and their discretion so extensive that it is unclear what they should focus on. In order for the discretion to work and practice to be well-functioning some boundaries and definitions are needed. If the discretion is the hole in the middle of the doughnut (Molandet et. al 2012) it does not work or exist without the organizational and legal boundaries which define it. Our study shows that increasing discretion and autonomy without also strengthening the professional understandings of what should be done and how a policy should be adopted and made meaningful in the local practice, will not reduce coping mechanisms and improve policy implementation. It will just create other types of coping.

In this light the results show, that coping mechanisms not just arise as a response to handling or avoiding individual moral dilemmas. It is can also be a way to navigate in policy landscapes that provides insufficient clarity and too vague definitions of what should be implemented. In order for policies to work professional as well as ethical and social competences should be present in the frontline (Maynard-Moody and Musheno 2002, Tummers et al. 2015, Zacka 2017, Cottam 2018). In our case the professional process of defining the content of the policy and making it meaningful in a local frontline practice is neglected. That is why the implementation is not successful.

In other words, the issue in our case is not too much direct steering. It is the lack of clarity as to what the policy means in practice and hence what practice are supposed to be steering towards – a managerial and organizational vacuum. This cause the frontline workers to adjust the policy to their already existing practice rather than altering the practice according to the policy. They keep turning their focus towards the children and youth they already agree upon being in serious need, 'the usual suspect', and thereby overlooking those whose problems are more trivial or 'normal' and at a stage where they are still preventable. As a result, they focus on the often endless needs of the drowning ones rather than trying to prevent the ones with wet feet from getting further into the water, as a

social worker in the study puts it. This task is much clearer and already well defined than the task of preventing vague or diffuse symptoms of vulnerability from developing into something much more serious. This is likely why the usual suspects keep getting all the focus.

Implementation as a process of anchoring knowledge

Our results illustrate the importance of not treating implementation as process where information about a policy change is simply passed from the management down through the organization until it reaches the frontline. Rather implementation in frontline organization should be understood also as process where new problem definitions, local meaning of core concepts and potential changes in definitions of target groups should be explicitly addressed, discussed and developed. Based on our results this process of assigning meaning and changing professional understandings of what should be done, why and for whom should not be left solely to the individual frontline worker. It is a professional process, which requires organizational and managerial attention and priority to make sure that time, resources and the right (new) knowledge is in fact available for the frontline workers. Thus when implementing policy changes to the frontline practice implementation should be understood and treated as much as a process taking new knowledge into use and adjusting it to actual and local professional practices as it should be viewed as changing organizational structures and informing about overall policy content and intentions. Therefore resources must be allocated and prioritized to anchor new knowledge in the organization by training the frontline workers not only in using particular tools or methods but more importantly in the knowledge and logic behind those methods and behind the changes which should be adapted. Without this the frontline workers cannot assign new meanings and definitions to their practice and the risk that the frontline therefore will continue business as usual despite new policies and suggested methods is high,

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Figure 1: frontline workers' perception of the concept 'prevention'

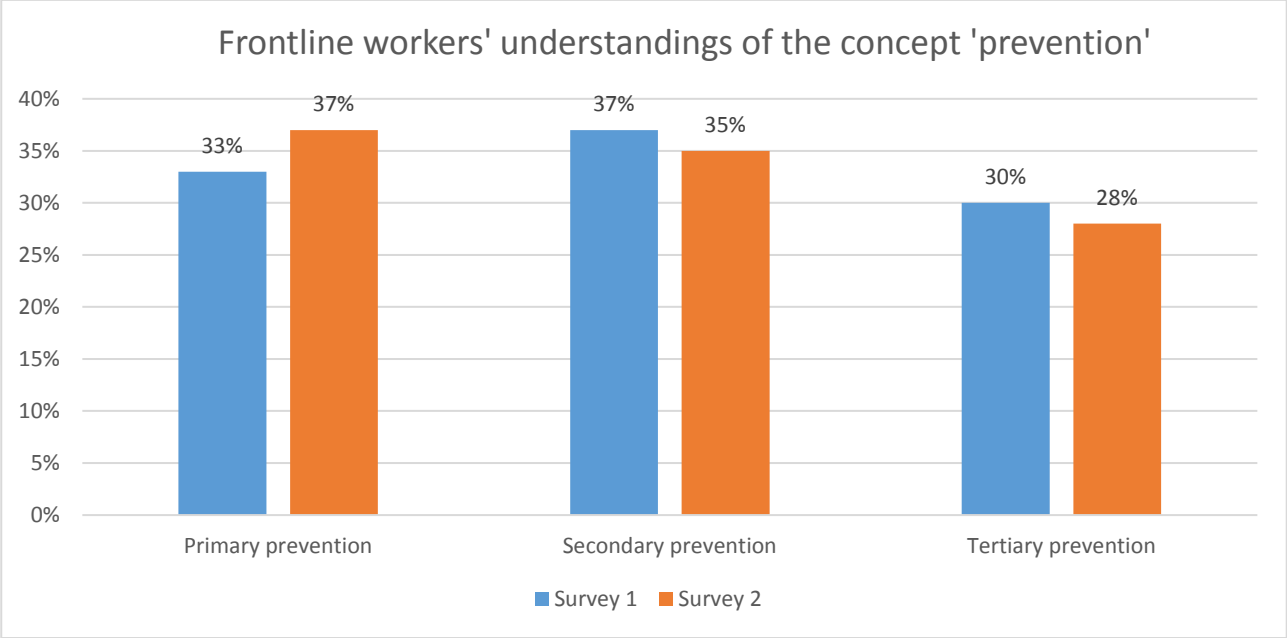

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Figure 2: Frontline workers' perception of the concept prevention based on profession

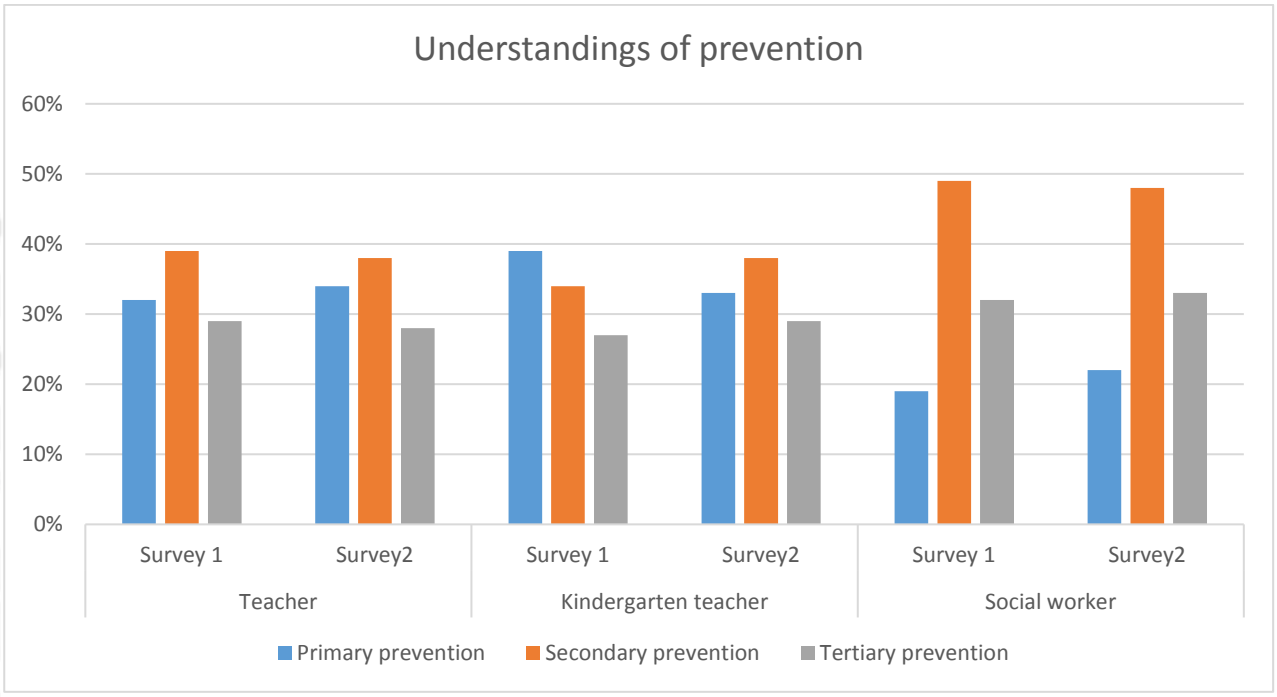

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Figure 3: Frontline workers' perception of risk factors

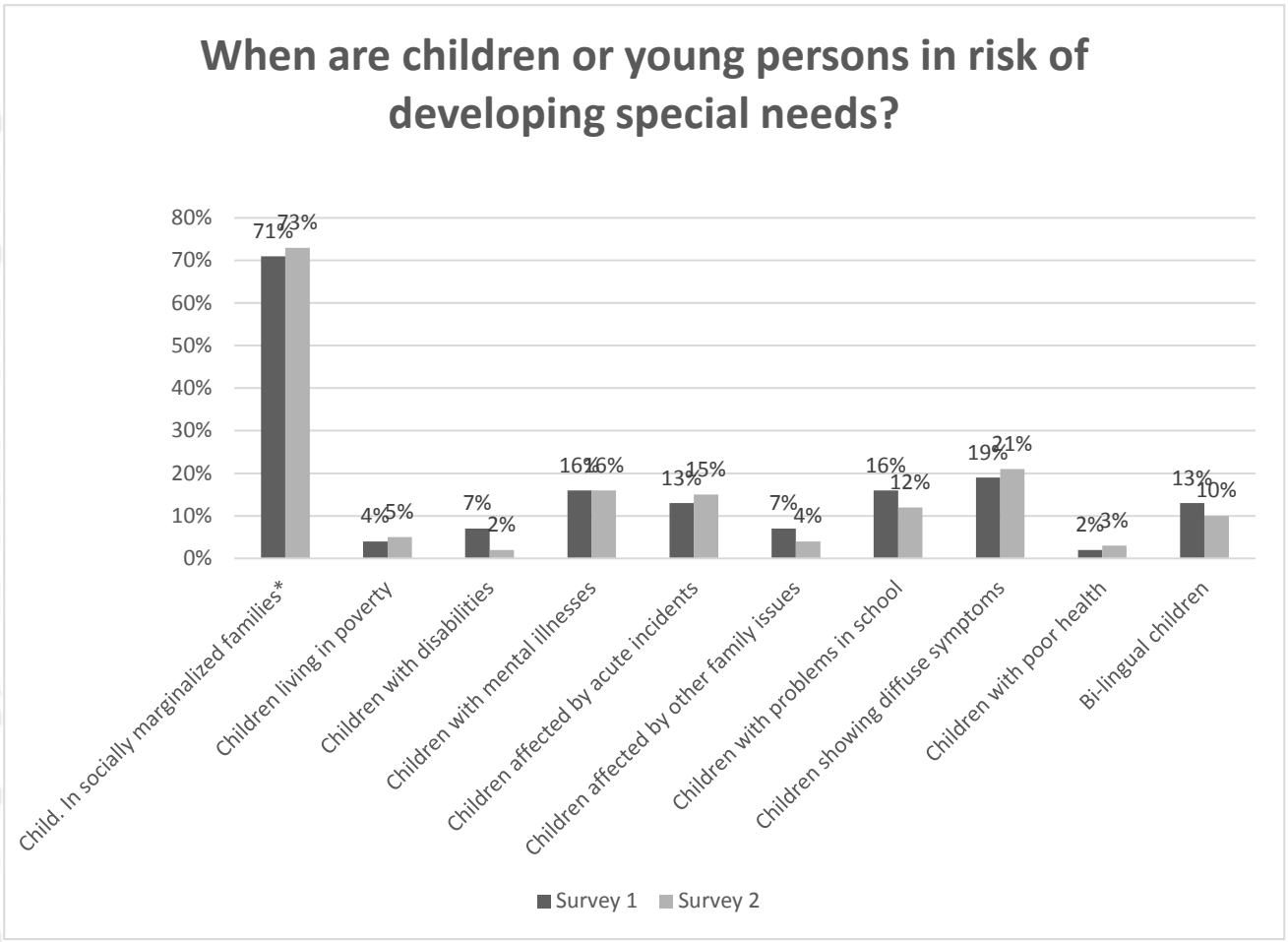

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Figure 4: Model 1, Social symptoms of vulnerability, survey 1, non-recursive, structural equation model, total effects.

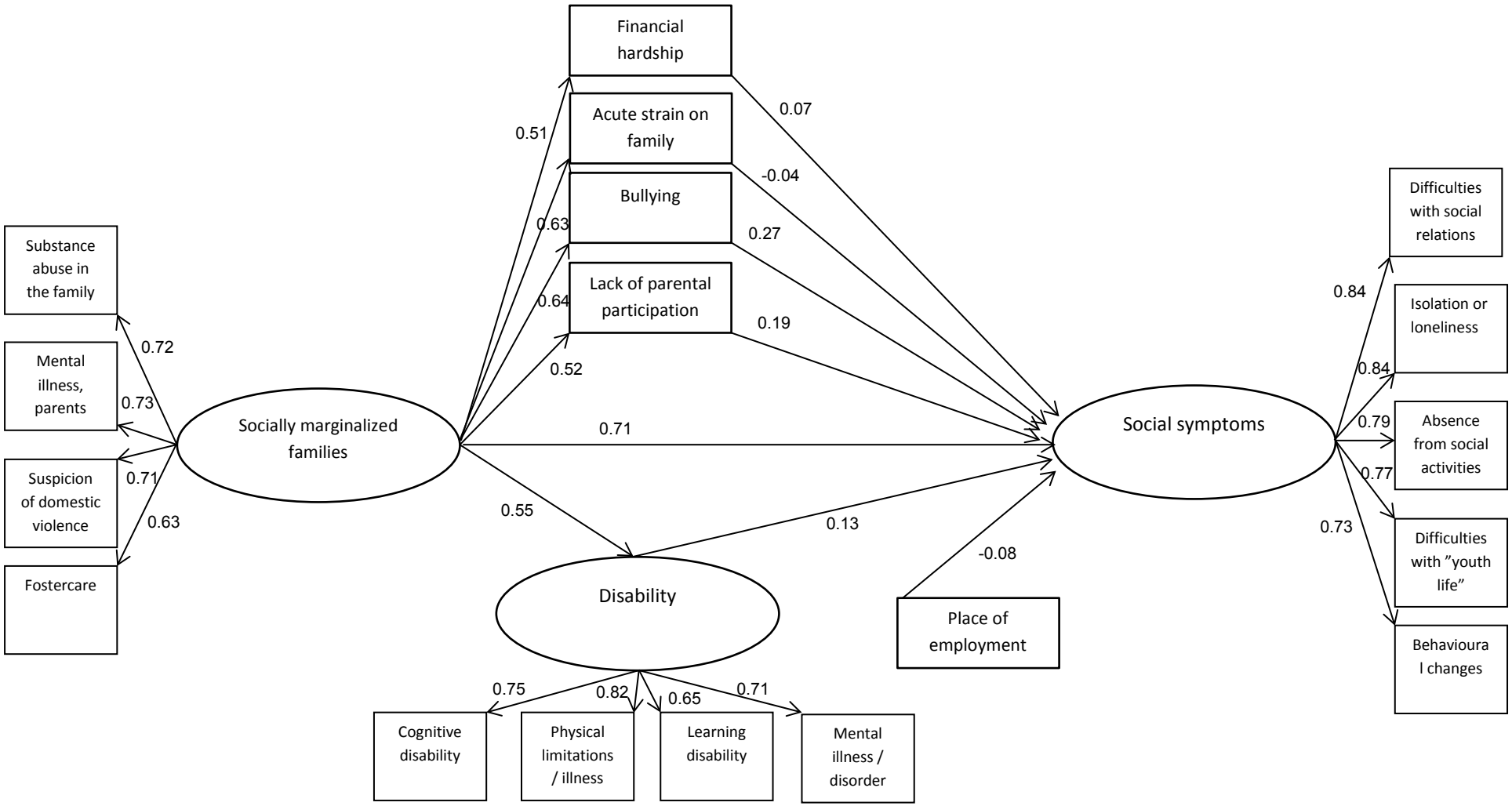


Figure 5: Model 1, Social symptoms of vulnerability, survey 2, non-recursive, structural equation model, total effects.

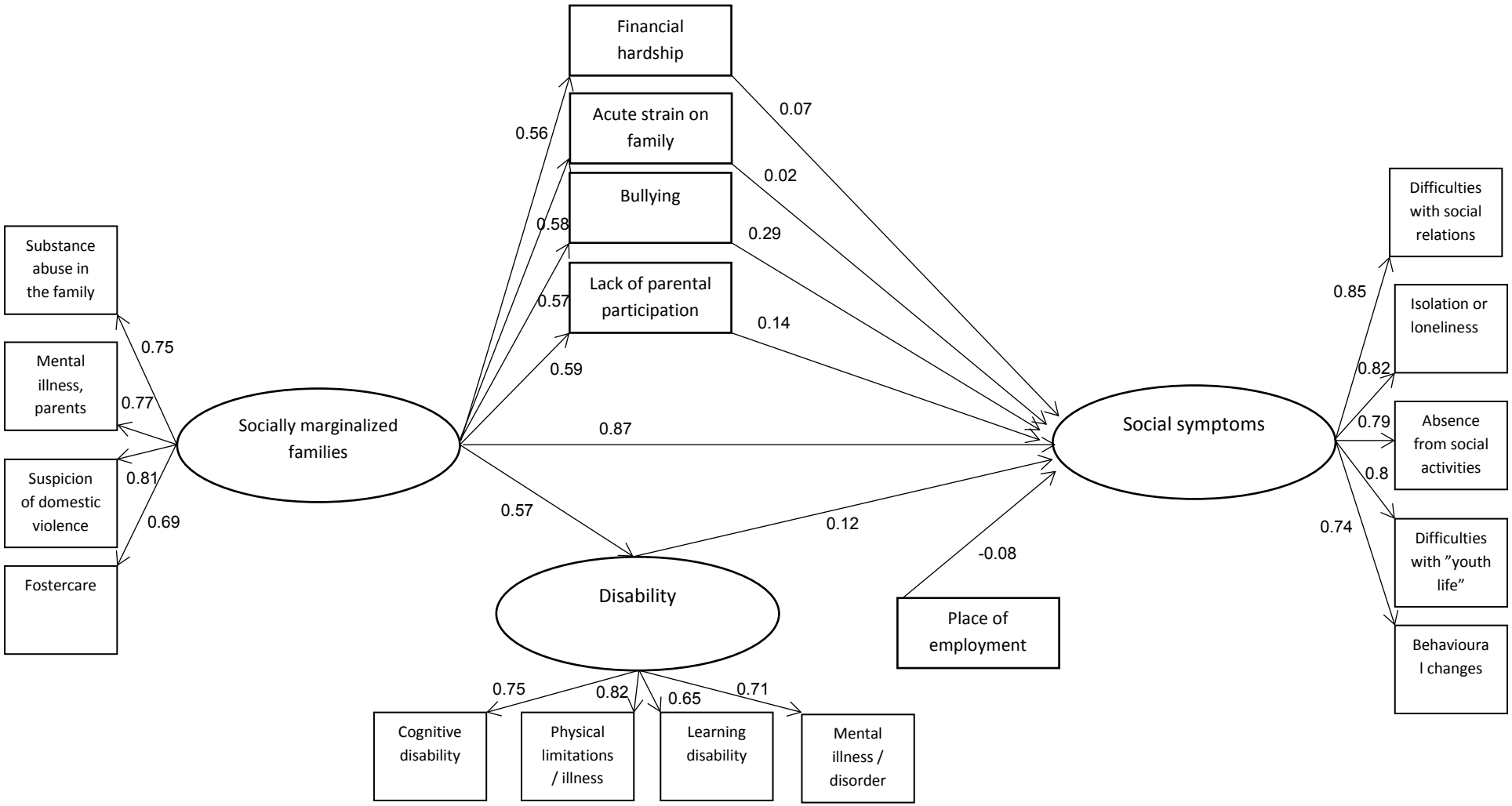


Figure 6: Model 2, Behavioral symptoms vulnerability, survey 1, non-recursive, structural equation model, total effects.

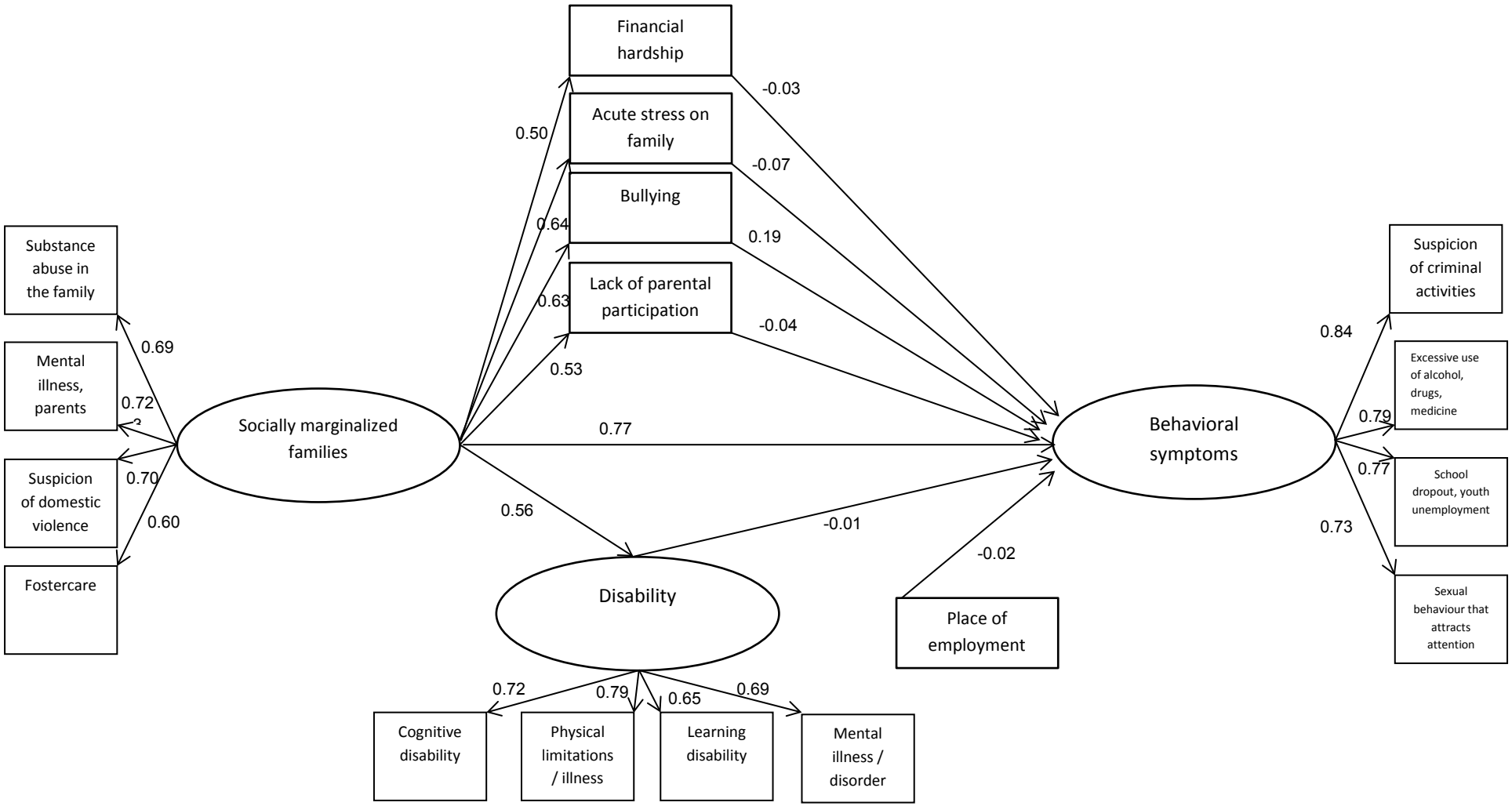
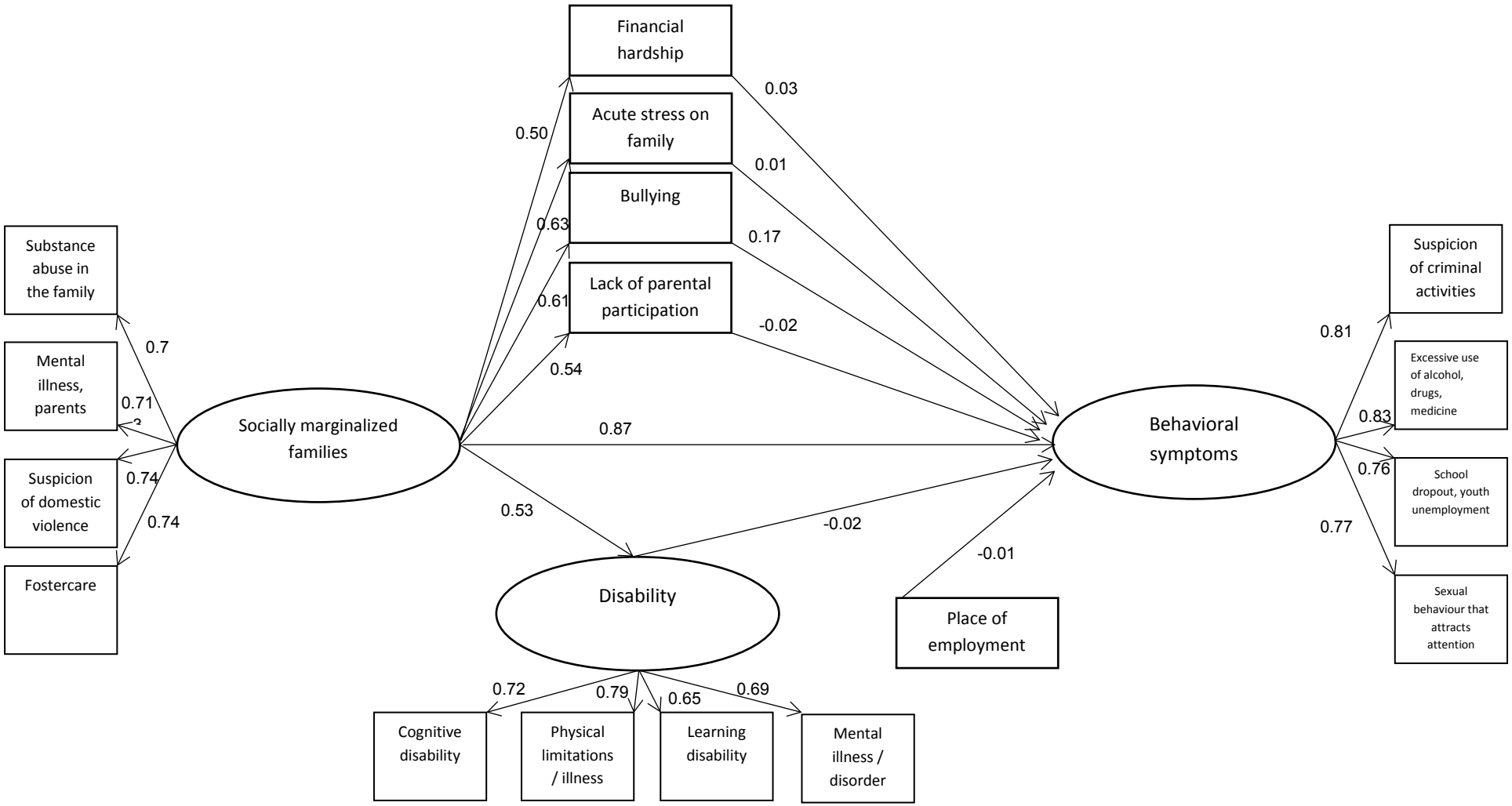


Figure 7: Model 2, Behavioral symptoms vulnerability, survey 2, non-recursive, structural equation model, total effects.



Table

Table 1: Fit statistics

	Model 1, Social Symptoms, survey 1	Model 1, Social Symptoms, survey 2	Model 2, Behavioral Symptoms, survey 1	Model 2, Behavioral Symptoms, survey 2	Criterion for good fit
Fit measure					
P>Chi2	0.000	0.000	0.000	0.000	$\leq$ 0.05
Root Mean Squared Error of approximation (RMSEA)	0.068	0.067	0.07	0.066	< 0.05
Comparative Fit Index (CFI)	0.9	0.91	0.93	0.92	> 0.9
Standardized Root Mean squared residual (SRMR)	0.07	0.06	0.08	0.08	< 0.1

Appendix

Table A1: Fit statistics

	Model 1, Social Symptoms, survey 1	Model 1, Social Symptoms, survey 2	Model 2, Behavioral Symptoms, survey 1	Model 2, Behavioral Symptoms, survey 2	Criterion for good fit
Fit measure					
P>Chi2	0.000	0.000	0.000	0.000	$\leq$ 0.05
Root Mean Squared Error of approximation (RMSEA)	0.068	0.067	0.07	0.066	< 0.05
Comparative Fit Index (CFI)	0.9	0.91	0.93	0.92	> 0.9
Standardized Root Mean squared residual (SRMR)	0.07	0.06	0.08	0.08	< 0.1

Table A2: Categorical ML estimates for the non-recursive structural equation model 1 based on data from survey 1

Parameter	Standardized coefficient	Ustandardized coefficient	Standard error
Direct effect on Social Symptoms			
Socially marginalized fam.* **	0.37	0. 56	0.09
Disability* **	0.13	0.11	0.03
Financial hardship **	0.07	0.04	0.01
Acute strain [ns]	-0.04	-0.03	0.02
Bullying* **	0.27	0.19	0.02
Lack of parental participation* **	0.19	0.12	0.02
Place of employment* **	-0.09	-0.23	0.06
Direct effect on Disability			
Socially marginalized fam.* **	0.56	1.06	0.08
Direct effect on Financial Hardship			
Socially marginalized fam.* **	0.51	1.17	0.08
Direct effect on Acute Strain			
Socially marginalized fam.* **	0.63	1.49	0.09
Direct effect on Bullying			
Socially marginalized fam.* **	0.64	1.34	0.08
Direct effect on Lack of Parental Participation			
Socially marginalized fam.* **	0.52	1.25	0.09
Indirect effect on Social Symptoms			
Socially marginalized fam.* **	0.35	0.54	0.06
Total effect on Social Symptoms			
Socially marginalized fam.* **	0.71	1.09	0.07
Disability* **	0.13	0.11	0.03
Financial hardship **	0.07	0.04	0.02
Acute strain [ns]	-0.04	-0.03	0.02
Bullying* **	0.26	0.19	0.02
Lack of parental participation* **	0.19	0.12	0.02
Place of employment* **	-0.08	-0.22	0.06
Adjusted R^2 (Social Symptoms)	0.62		

Notes: *** Coefficient is significant at the 0.001 level, ** the coefficient is significant at the 0.01 level, * coefficient is significant at the 0.05 level, *ns* coefficient is not significant.

Table A3: Categorical ML estimates for the non-recursive structural equation model 1 based on data from survey 2

Parameter	Standardized coefficient	Ustandardized coefficient	Standard error
Direct effect on Social Symptoms			
Socially marginalized fam.* **	0.41	0.59	0.09
Disability* **	0.12	0.10	0.02
Financial hardship **	0.07	0.04	0.01
Acute strain [ns]	0.02	0.01	0.02
Bullying* **	0.29	0.20	0.03
Lack of parental participation* **	0.24	0.15	0.02
Place of employment* **	-0.08	-0.23	0.06
Direct effect on Disability			
Socially marginalized fam.* **	0.57	1.07	0.07
Direct effect on Financial Hardship			
Socially marginalized fam.* **	0.56	1.22	0.08
Direct effect on Acute Strain			
Socially marginalized fam.* **	0.58	1.45	0.1
Direct effect on Bullying			
Socially marginalized fam.* **	0.57	1.3	0.07
Direct effect on Lack of Parental Participation			
Socially marginalized fam.* **	0.69	1.34	0.08
Indirect effect on Social Symptoms			
Socially marginalized fam.* **	0.46	0.77	0.06
Total effect on Social Symptoms			
Socially marginalized fam.* **	0.87	1.36	0.05
Disability* **	0.12	0.10	0.02
Financial hardship **	0.07	0.04	0.01
Acute strain [ns]	0.02	0.01	0.02
Bullying* **	0.29	0.20	0.03
Lack of parental participation* **	0.24	0.15	0.02
Place of employment* **	-0.08	-0.23	0.06
Adjusted R^2 (Social Symptoms)	0.64		

Notes: *** Coefficient is significant at the 0.001 level, ** the coefficient is significant at the 0.01 level, * coefficient is significant at the 0.05 level, *ns* coefficient is not significant.

Table A4: Categorical ML estimates for the non-recursive structural equation model 2 based on data from survey 1

Parameter	Standardized coefficient	Ustandardized coefficient	Standard error
Direct effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.74	1.06	0.1
Disability[ns]	-0.01	-0.01	0.03
Financial hardship[ns]	-0.03	-0.02	0.02
Acute strain [ns]	-0.02	-0.04	0.02
Bullying* **	0.19	0.13	0.02
Lack of parental participation [ns]	-0.04	-0.03	0.02
Place of employment [ns]	-0.02	-0.05	0.06
Direct effect on Disability			
Socially marginalized fam.* **	0.55	1.06	0.09
Direct effect on Financial Hardship			
Socially marginalized fam.* **	0.52	1.18	0.08
Direct effect on Acute Strain			
Socially marginalized fam.* **	0.62	1.48	0.08
Direct effect on Bullying			
Socially marginalized fam.* **	0.63	1.33	0.08
Direct effect on Lack of Parental Participation			
Socially marginalized fam.* **	0.51	1.24	0.09
Indirect effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.03	0.04	0.07
Total effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.77	1.1	0.06
Disability [ns]	-0.01	-0.01	0.03
Financial hardship [ns]	-0.03	-0.02	0.02
Acute strain [ns]	-0.07	-0.04	0.02
Bullying* **	0.19	0.13	0.03
Lack of parental participation [ns]	-0.04	-0.02	0.02
Place of employment [ns]	-0.02	-0.05	0.06
Adjusted R^2 (Behavioral Symptoms	0.62		

Notes: *** Coefficient is significant at the 0.001 level, ** the coefficient is significant at the 0.01 level, * coefficient is significant at the 0.05 level, *ns* coefficient is not significant.

Table A5: Categorical ML estimates for the non-recursive structural equation model 2 based on data from survey 2

Parameter	Standardized coefficient	Ustandardized coefficient	Standard error
Direct effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.76	1.07	0.09
Disability[ns]	-0.02	-0.02	0.03
Financial hardship[ns]	0.03	0.02	0.02
Acute strain [ns]	0.01	0.03	0.02
Bullying* **	0.17	0.12	0.01
Lack of parental participation [ns]	-0.02	-0.01	0.02
Place of employment [ns]	-0.01	-0.04	0.05
Direct effect on Disability			
Socially marginalized fam.* **	0.53	1.05	0.07
Direct effect on Financial Hardship			
Socially marginalized fam.* **	0.50	1.16	0.08
Direct effect on Acute Strain			
Socially marginalized fam.* **	0.63	1.49	0.09
Direct effect on Bullying			
Socially marginalized fam.* **	0.61	1.31	0.09
Direct effect on Lack of Parental Participation			
Socially marginalized fam.* **	0.54	1.27	0.09
Indirect effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.11	0.02	0.05
Total effect on Behavioral Symptoms			
Socially marginalized fam.* **	0.87	1.27	0.06
Disability [ns]	-0.02	-0.02	0.03
Financial hardship [ns]	0.03	0.02	0.02
Acute strain [ns]	0.01	0.03	0.02
Bullying* **	0.17	0.12	0.01
Lack of parental participation [ns]	-0.02	-0.01	0.02
Place of employment [ns]	-0.01	-0.04	0.05
Adjusted R^2 (Behavioral Symptoms	0.62		

Notes: *** Coefficient is significant at the 0.001 level, ** the coefficient is significant at the 0.01 level, * coefficient is significant at the 0.05 level, *ns* coefficient is not significant.