CHAPTER I

THE PATERNITY PROBLEM

Colorado, like the nation as a whole, has experienced a dramatic rise in the number of births to unmarried women. In 1950, only 3 percent of all births in Colorado occurred out of wedlock. By 1991 the proportion had increased to 23.6 percent. Nationally, the rate of non-marital births was 30.1 percent in 1992.

Although recent evidence shows a rise in out-of-wedlock births among women in their twenties and thirties and with higher levels of educational and occupational attainment (Bachii, 1993), unmarried parentage is still concentrated among the poor and is associated with further impoverishment. The most disadvantaged demographic group in the U.S. is children of single-parent families (Garfinkel & McLanahan, 1986). Within this group, children living with never-married mothers are the poorest. In 1992, 55.8 percent of Colorado families receiving Aid to Families with Dependent Children (AFDC) were eligible because of father-absence due to non-marriage (Green Book, 1994: Tables 10-35).

One factor contributing to their low incomes is the fact that most never-married women fail to become eligible to receive child support. Nationally, it appears that only about one-quarter of the never-married mothers had established paternity for at least one of their children in 1986. This was corroborated in a 1990 survey of Colorado households where only one-quarter of the unmarried parents had established paternity through legal action (Pearson, Anhalt and Thoennes, 1991). In fiscal year 1992, paternity had been established in only 27 percent of AFDC households with an absent father due to non-marriage (Green Book, 1994: Tables 10-35).

As a result of the low rate of paternity establishment, most never-married women never get a child support order. Census data reveal that only 24 percent of never-married women have a child support order and are legally eligible to receive support. In contrast, 77 percent of all divorced women have child support orders (U.S. Bureau of the Census, 1991). Once a child support order is obtained, never-married women are equally likely to receive payment as their divorced counterparts. Thus, regardless of their marital status, about half of the women with child support orders receive full payment while a quarter receive no payment at all and another quarter only receive partial payment. However, since average annual child support receipts for never-married women fall below receipts for separated and divorced women, even never-married women with child support fare badly economically. Taken together, the average never-married woman received only $273 annually in child support compared to $951 for separated women and $1,776 for divorced women (U.S. Bureau of the Census, 1991).

Not surprisingly, poverty rates are extremely high for never-married mothers and their children. In 1989, 54 percent of never-married women with minor-aged children lived below the poverty level. For divorced mothers with minor children, the percent at or below the poverty level was 27 percent. For all families with children, the percent at or below the poverty level was 15 percent (U.S. Bureau of the Census, 1991). Further evidence of the disadvantaged status of

never-married mothers and their children comes from profiles of participants in the Aid for Families with Dependent Children program. In 1987, 57 percent of single-parent AFDC children were born out-of-wedlock, while 40 percent came from parents who were divorced or separated (Meyer, 1992a). Never-married women on AFDC tended to receive assistance the longest. On average, divorced women received 4.9 years of AFDC while never-married women received AFDC for 9.3 years (Ellwood, 1986).

Patterns in Colorado track with the national profile. A 1990 survey of Colorado households revealed that more than half of the state's never-married women with minor-aged children lived below the poverty level. Unmarried parents likely to have child support orders had court-ordered paternity. Only 32 percent of women with birth certificate-acknowledged paternity had child support orders and another 18 percent had informal, written agreements (Pearson, Anhalt & Thoennes, 1991).

Children born out-of-wedlock experience other deprivations along with financial ones. For example, they have the lowest levels of contact with absent fathers. In a Baltimore study of teenage childbearing, only about a third of the never-married fathers saw their adolescent children at least once a month. Evidence from the 1981 National Survey of Children showed even lower levels of contact--21 percent of the black youth and 6 percent of whites between the ages of 11 and 16 whose parents never married had seen their father once a month or more in the past year (Furstenberg and Cherlin, 1991).

The establishment of paternity in unmarried births is seen as one way to address the deprivations associated with out-of-wedlock parentage. Among the recognized medical benefits to paternity establishment is knowledge about the father's genetic background, including potential inherited disorders which allow appropriate medical care to be provided, and the possibility of the father being the life-saving donor of bone-marrow, a kidney or other organs in a medical emergency. The emotional and psychological benefits of paternity include the opportunity to identify with the paternal half of a child's ancestral roots, and to know and explore family heritage, culture and religious ties. Paternity may also lead to the opportunity to establish a parent-child relationship and the exercise of paternal contact and access to the paternal family (Hoover, 1991).

Among the many social entitlements that ensue from paternity are the ability to realize inheritance proceedings, survivor benefits through social security, and dependent benefits under workman's compensation if the father is injured on the job. If the father is a member of the armed forces, or becomes a member, paternity can lead to monthly dependent benefits, educational benefits and military health care and insurance.

Finally, paternity establishment may lead to important financial benefits. Evidence of paternity is needed if the mother wants child support. Evidence of paternity can also lead to

dependent health care coverage if the father's employer has insurance and a share of unemployment compensation if the father is unemployed. The fact that many unmarried fathers have little or no income when their babies are born does not mean they will always have limited means. For example, while more than half of teen-aged fathers have zero incomes at the time the paternity petition is filed, less than 20 percent have zero incomes at age 30. A recent study showed that, on average, income for fathers in paternity actions increased by $4,000 during the three years following the filing of the paternity petition (Meyer, 1992b).

Despite the benefits of paternity establishment to the child and to society as a whole, performance in paternity establishment has been exceptionally poor. Paternity cases have historically received low priority in child support agencies (Bernstein 1982; Kohn 1987). Accordingly, few children of unmarried fathers have paternity established, get child support orders or obtain support. For example, in 1988, the paternity establishment rate for the nation as a whole stood at 30 percent. Thirty-two states scored below 30 percent; forty-five scored below 50 percent (Office of Inspector General, 1990). In April 1987, the General Accounting Office found that 4 of every 10 AFDC children who needed paternity determinations for support orders (41 percent) did not receive them because their cases were never opened, were closed prematurely or remained open but unattended (G.A.O., 1987).

Paternity researchers are unanimous in concluding that the best time to establish voluntary paternity is at the time the child is born and that the likelihood of establishing paternity declines as children age (Danziger and Nichols-Casebolt, 1988). The first year of a child's life has been termed "a window of opportunity for establishing paternity" that is not encountered at later stages in the child's life. Indeed, the most propitious moment for paternity establishment is at the hospital at the time of birth. For example, a study of unmarried teen-aged parents found that 80 percent thought it was important for the father's name to be on the birth certificate (Wattenberg et al, 1991). These researchers also found that the opportunities for contact and success that are present at the time of birth quickly fade. A follow-up study one year after the child's birth, which attempted to conduct interviews with young, unmarried fathers and mothers, was thwarted by disconnected telephones, letters returned "address unknown" and tracking efforts that failed. As a result of their experiences, these researchers recommend the following steps:

- ❑ Make paternity acknowledgement materials routinely available in hospital settings and focus attention on supporting the parents' decision to acknowledge paternity while mother and baby are still in the hospital.

- ❑ Make materials (written and oral) in appropriate languages available to both parents which describe the benefits to children that flow from paternity acknowledgement.

- ❑ Treat voluntary paternity establishment as an isolated issue and make it separate from issues such as child support, visitation rights and custody.

- ❑ Combine paternity establishment with a more comprehensive information program geared to social services, health and other interventions for children, youth and families.

- ❑ Maintain existing exceptions in policy and procedure to allow for instances where the legal link of father to child should not be encouraged.

In recent years there has been a "flurry" of legislative initiatives aimed at obtaining paternity acknowledgements at the time of birth. One provision of the Family Support Act of 1988 required that states meet specific quantifiable goals for establishing paternity (Maniha, 1992). More recently, a federal law was enacted requiring that each state develop a simple administrative process for voluntarily acknowledging paternity and create a hospital-based program for voluntary acknowledgements (Omnibus Budget Reconciliation Act of 1993 [P.L. 103-66]). The state with the longest experience with such efforts is Washington, which passed a law in 1991 requiring that medical records and hospital personnel provide written and oral information about paternity and/or the opportunity for unwed parents to acknowledge paternity. Preliminary evaluation results regarding the effectiveness of this hospital-based paternity program in Washington are encouraging. In a period prior to the inception of the in-hospital paternity effort, paternity establishments for out-of-wedlock children aged 4-5 years old occurred in only 17 percent of the cases. Following the routine use of in-hospital orientations, voluntary paternities rose to 33 percent of all relevant births in Tacoma General, the state's largest community hospital serving a high concentration of unmarried women (Hoover, 1991). Washington estimates that 40 percent of unmarried births will be accompanied by acknowledgements (Cleveland and Williams, 1992).

In light of the obvious benefits of paternity, the Colorado Department of Child Support Enforcement applied for and received a Child Support Enforcement improvement grant (91-4-PI-CO-00) in 1991, one component of which was aimed at initiating a pilot paternity demonstration. The multi-year grant involved streamlining the voluntary paternity acknowledgement process in several Denver-area hospitals, and introducing and evaluating the effectiveness of various efforts to disseminate information about paternity in-hospital settings. Since the award was made, the project has involved the following:

- ❑ Introduction of in-hospital paternity acknowledgement at four metro area hospitals.

- ❑ Conduct of daily outreach efforts about paternity with unmarried mothers on an individual basis in postpartum settings in four metro area hospitals.

- ❑ Simplification of the voluntary paternity acknowledgement process to remove procedural and financial barriers.

- ❑ Development and enactment of a statewide law requiring medical institutions to grant unmarried parents an opportunity to complete an affidavit acknowledging paternity.

- ❑ Joint discussions of paternity establishment by staff at Colorado's child support and vital records agencies leading to the production of the Handbook for Hospital-Based Paternity Acknowledgement.

- ❑ Production and distribution of English and Spanish language materials on paternity and the acknowledgement process.

- ❑ Edit of a 7-minute video on paternity acknowledgement to be used with unmarried parents in prenatal and postpartum forums.

- ❑ Conduct of training on paternity acknowledgement for various hospital audiences.

- ❑ Conduct of a comprehensive evaluation of the in-hospital paternity effort with emphasis on changes in rates of acknowledgement and the characteristics of those who acknowledge versus those who disavow paternity.

The following chapters describe some of the lessons we have learned in the course of implementing and evaluating Colorado's paternity project. In Chapter II, we describe the legal, procedural, and administrative factors that came into play in implementing an in-hospital paternity overture in four hospitals in the Denver area. In Chapter III, we discuss voluntary paternity acknowledgement patterns prior to the initiation of the pilot project. In Chapter IV, we describe the impact of the in-hospital outreach effort on acknowledgement levels. In Chapter V, we describe the demographic characteristics of unmarried parents who voluntarily acknowledge. In Chapter VI, we present the financial correlates and consequences of voluntary paternity acknowledgement. In Chapter VII, we describe the reasons for paternity acknowledgement and disavowal given by unmarried parents themselves. Finally, in Chapter VIII we summarize project findings and discuss their implications for policy.

CHAPTER II

LEGAL, PROCEDURAL AND ADMINISTRATIVE CONSIDERATIONS IN IMPLEMENTING IN-HOSPITAL PATERNITY ACKNOWLEDGEMENT EFFORTS

The Colorado Paternity Demonstration Project involved implementing in-hospital voluntary paternity acknowledgement procedures at four hospitals in the Denver area. These facilities are University, Denver General, Saint Joseph, and Mercy Hospitals.

At each facility, arrangements were developed to routinely inform unmarried parents about paternity and offer them the opportunity to voluntarily acknowledge prior to or immediately following their discharge from the hospital. In addition, the Department of Social Services (DSS) assumed payment of all fees associated with the establishment process and handled the paper work that had previously fallen to parents to do.

Implementing hospital-based efforts to encourage unmarried parents to acknowledge paternity has required many accommodations. It has been necessary to simplify the process by which the paternity affidavit may be completed and filed with the Bureau of Vital Statistics (BVS). It has been necessary to gain admittance to hospitals and negotiate the terms and conditions under which patients may be approached. In the course of these negotiations, it has been necessary to address a variety of concerns that hospital administrators, medical personnel, social workers and birth certificate clerks have about paternity establishment programs and their placement in the hospital setting.

The following describes some of the lessons we have gleaned through the process of implementing in-hospital paternity programs in four different settings.

A. Administrative Authority and Procedure

Perhaps the key lesson to be learned from Colorado's experience is the importance of a streamlined and simplified paternity acknowledgement procedure. When the project began, the establishment process in Colorado was cumbersome, time consuming, expensive and extremely discouraging even to interested, unmarried parents. Although a voluntary acknowledgement process existed that provided for paternity to be established on a presumptive basis, there was no effort to explain the benefits of paternity to unmarried parents or to make the option available. More to the point, the Colorado Bureau of Vital Statistics (BVS) did not permit the father's name to be added to the birth certificate at the time of birth even if he was willing to sign the affidavit. Rather, the procedure was for the certificate to be completed without the father's name and submitted to the state for entry on its database. Approximately 15-20 days later, when the

registered birth certificate was returned to the mother, the father could obtain a Statement of Paternity from BVS. The father's name was added only if the Statement of Paternity included notarized signatures for both parents and a fee of $27 was sent to BVS. This included a $15 fee to process the change and a $12 fee for a certified copy of the new birth certificate. The new birth certificate with the father's name was usually not available until three to four months following the birth of the baby. Women who had been previously married faced additional hurdles. They were required to produce a certified copy of their divorce decree before the father of the child could be added to the birth certificate using the above noted procedure.

Not surprisingly, paternity establishment rates were low in Colorado hospitals and the process took a very long time. In 1991, a year that clearly preceded the introduction of the project, voluntary acknowledgements at Denver General stood at only 13 percent. At University Hospital, paternity was voluntarily acknowledged in 22 percent of the unmarried births. At Mercy and St. Joseph Hospitals, percentages of voluntary acknowledgements were 24 and 20 percent, respectively.

Following commencement of the project, the fee and time requirements for voluntary paternity acknowledgements posed by BVS were examined and amended. At first, procedural modifications were made only in selected hospitals participating in the project. Subsequently, the changes were adopted state-wide as a result of the enactment of new legislation.

Under state law adopted in 1993 (HB 93-1227), all hospitals are required to make the voluntary acknowledgement process available to unmarried parents at the time of birth. Interested parents have the option of signing a notarized paternity affidavit at birth and having the father's name placed on the birth certificate. If the affidavit is signed within ten days of the baby's birth, there is no fee to the parent associated with the entry. These procedures cover previously married women as long as they were not married either at the time of conception or birth. Finally, for women who were married at these times, the husband and the father of the child may execute notarized documents permitting the father's name to be entered on the birth certificate rather than the husband's (see Appendix A).

Effective July 1994, the process was made even more accessible to unmarried parents when the requirement for notarized signatures was replaced with witnessed ones (see Appendix B). It was hoped that this change would address the problem of a lack of notary publics in hospital settings.

B. Relationships With the Bureau of Vital Statistics

While new laws and simplified administrative procedures are necessary elements of an enhanced paternity acknowledgement process, they are not sufficient. A second key ingredient to a successful voluntary acknowledgement process is coordination between the Child Support

Enforcement Division and the Bureau of Vital Statistics. Coordination is needed to ensure that: unmarried parents are routinely approached in hospital settings; birth registration clerks receive training in the voluntary acknowledgement process; hospital-specific performance patterns with respect to paternity can be systematically monitored; and birth certificates can be readily screened by child support workers to determine whether paternity has been voluntarily acknowledged.

The Colorado Paternity Project stimulated many joint discussions between BVS and the child support enforcement unit of the Denver Department of Social Services (DDSS). One outcome of these meetings was the joint production of the Handbook for Hospital-Based Paternity Acknowledgement. In addition to describing the new procedure and presenting all relevant forms, the Handbook identified IV-D contact persons in each county who will serve as liaisons to the hospitals.

Another area of mutual interest is staff training. Following the passage of state law requiring hospitals to make the paternity affidavit available to parents, project staff initiated a state-wide training effort aimed at exposing birth registration clerks and other relevant hospital workers to the paternity issue and the new law. Although this training has been well received, it has demonstrated a need for more sustained training attention. Personnel turnover in hospital settings is high. In order to ensure that new birth registration clerks, nursing staff and discharge planners are aware of the benefits of paternity and the voluntary acknowledgement process, presentations about paternity must be incorporated in the regular training accorded to these types of workers.

Still another outcome of the joint meetings between BVS and DDSS inspired by the project was the development of quarterly data downloads from BVS showing voluntary acknowledgement patterns by hospital facilities. With this performance-based information, project personnel are better able to monitor voluntary acknowledgements at the hospital level and target facilities in need of training and technical assistance.

A recognized, needed area of collaboration between BVS and the state child support agency, which was not accomplished by the conclusion of the project, was the development of an automated interface between the two agencies. The goal of the interface would be to permit child support workers to screen birth certificates on terminals at their own agency for the purpose of identifying whether a father's name is on the birth certificate and whether a child support case requires that paternity be established. Currently, child support workers must request a copy of the birth certificate in order to check whether a father has acknowledged paternity. With an automated link, this information would be available instantaneously during a relevant intake procedure.

C. Access to Hospitals

Another key ingredient to the voluntary acknowledgement process is gaining admittance to hospitals in order to meet with pregnant and newly delivered unmarried mothers and their partners. While there has been no single pattern to the reaction of administrators and staff in the four hospital settings in which the Colorado pilot has been implemented, a number of issues have been raised in one or more of these settings that may be relevant to program replications. These patterns are discussed below.

Human Subject Review Boards

Because our project was initiated prior to the passage of state-wide legislation, and because it had an evaluation component, three of the four Denver area hospitals in which project interventions occurred required project evaluators to prepare extensive written proposals outlining project procedures and anticipated risks to patients and submit them for review by the respective governing Institutional Review Board. Although all the submitted proposals were ultimately approved, the Human Subject Review Board process was lengthy and time consuming. The Boards were interested in learning about all aspects of the project, including the collection and use of any evaluative information. Indeed, one Board contemplated the requirement that project staff obtain a signed, informed consent form from unmarried parents prior to presenting information about paternity. Fortunately, the plan was abandoned when it was noted that the consent form would be more invasive than the paternity acknowledgement process itself. Reviews by Human Subject Review Boards appear to be unnecessary once a state law requiring in-hospital paternity is enacted. However, Board approval is often necessary if any patient-specific information on the impact of in-hospital efforts is to be collected, even after the enactment of a law requiring in-hospital outreach.

Hospital Image

Hospital image factors have also come into play. For example, one hospital which had permitted project staff to make prenatal overtures to unmarried mothers in clinic waiting rooms, decided to discontinue its clinic format and move to an individual appointment system. Moreover, when pregnant women were seen in a group for instruction on nutrition and other issues of pregnancy, the hospital did not want to offend married women by discussing the paternity issue. As a result, it became impossible for staff to make the overture prenatally.

Restrictions on Patient Contact

Three of the four project hospitals granted child support staff access to patients to conduct the paternity interventions. From the start of the project, they placed no restrictions on the use of non-hospital personnel in prenatal or postpartum settings. In one of the four hospitals, however, outsiders were prohibited from making contact with patients for the first year of the project.

After lengthy negotiations at this hospital, the child support agency (DDSS) agreed to fund an entry level social work position and the hospital agreed to hire a social worker for the exclusive purpose of conducting paternity orientations. The arrangement lasted for about a year. During this time, this worker was jointly supervised by DDSS and the hospital's social work department. There were several limitations to this arrangement. One was the inability to provide back-up for the social worker during weekends and personal leave days. Another limitation of this arrangement was the requirement to comply with the hospital social work department's time-consuming procedures for documenting patient contacts. After a year of experimentation, evaluation and negotiation, the hospital relented and agreed to allow DDSS personnel to make the paternity presentations to unmarried parents.

D. Personnel to Make the Paternity Overture

There were several considerations to take into account in determining who should make the paternity overture in hospital settings. Scheduling considerations were critical. It was necessary to provide coverage throughout the week, including weekends, holidays and personal leave days. Until the requirement for notarization was dropped, it was also important to have personnel available at the hospitals who could notarize the fathers' signatures during evening and other non-traditional work hours. In addition, since successful paternity interventions are positive and energetic, it was necessary to identify motivated and committed personnel in every hospital setting. A final consideration had to do with workload concerns. Hospital workers, like birth registration clerks, may object to the prospect of being asked to assume a new responsibility without any increase in staff support or remuneration. Not surprisingly, there are definite pluses and minuses to using different types of personnel to make paternity overtures.

Child Support Workers

We relied on child support workers to staff the in-hospital paternity effort in most of the participating hospitals in this project. There were several reasons for this staffing decision. The project began before there was a state-wide law requiring hospitals to present the paternity option to unmarried parents. There was some question as to whether birth registration clerks would assume this duty without a legal requirement to do so.

Another reason in favor of using DDSS workers was the proximate location of several hospitals with large numbers of out-of-wedlock births. This made it feasible for a DDSS worker to visit several hospitals on a daily basis to meet with unwed mothers and fathers following delivery. Moreover, since DDSS workers share the agency's desire to improve its Paternity Establishment Percentage, they proved to be highly motivated and effective presenters. Another strength that DDSS workers brought to the job is working knowledge of the child support and benefit systems. They were able to handle the questions that parents had about these issues.

When notarization was necessary, it was easy to make child support workers notary publics. Consequently, they were able to complete the paternity affidavit with its requirement for notarized signatures for each parent. Finally, DDSS workers willingly accommodated the client documentation and data collection requirements of the project evaluation.

The chief drawback to this arrangement obviously is its cost. While it is not overly time consuming for a DDSS worker in Denver to visit several high volume hospitals on a daily basis, this might be impractical in rural settings and in urban settings with more traffic congestion. Another limitation is the lack of evening coverage. While DDSS workers may effectively reach all mothers in the course of a daily visit, they cannot catch all unmarried fathers. Thus, the use of DDSS personnel does not eliminate the need to have hospital personnel, who are notaries (when notarization is necessary), available to accommodate unmarried fathers whenever they show up to visit, including evenings when the DDSS worker is not on the scene. A final drawback to using DDSS workers is their affiliation with the child support and welfare programs. To maximize their acceptance by unmarried parents, workers have found it helpful to dissociate themselves from the agency and present themselves as paternity "workers."

Over time, birth registration clerks at each of the project hospitals assumed the paternity orientation function and DDSS workers were phased out of the process in Denver. The project DDSS worker succeeded in training each hospital's birth registration clerk to assume a more aggressive role in paternity establishment. Given the turnover in birth registration clerks and other labor and delivery personnel in hospital settings, however, it will be necessary to develop a mechanism for continual training of new workers in the paternity acknowledgement process.

Social Workers

Moving beyond scheduling and work-load considerations, we have found that different hospital staff evoke reactions in unmarried parents that can be either helpful or harmful to the paternity overture. For example, in the one hospital setting where the overture was made by a hospital social worker, it was helpful to minimize the connection between the paternity orientation and the social work function. Due to their work in the child protection arena and the increasing number of child placements that occur as a result of the rising use of drugs among pregnant and newly delivering mothers in inner cities, social workers are often feared and mistrusted by unmarried mothers at delivery. The project social worker found it helpful to merely introduce herself as a paternity worker and to de-emphasize her affiliation with the hospital's social work department.

Nurses

Nursing staff have access to unmarried mothers and are generally trusted. On the other hand, they are typically uninformed about the paternity issue and/or too busy to address this issue

along with everything else they do. With hospital training efforts, it might be possible to convince staff to incorporate paternity with other parent education functions they perform. For example, in one hospital, nurses conduct a daily discharge class where the paternity issue might logically be addressed. Unfortunately, the private views of presenting personnel may come into play. In this hospital, one nurse handling the class was opposed to paternal involvement and urged mothers not to sign the affidavit. As a result of project intervention, negative instructions were discontinued; however, they were not replaced with a positive message.

Birth Registration Clerks

Birth registration clerks are clearly the most logical workers to make the paternity overture. However, they too face pressures that conflict with the goals of the paternity intervention. The chief one is the pressure to submit the birth certificate worksheet to BVS as quickly as possible. Often, this prevents clerks from giving unmarried parents time to think about the paternity decision. They may be reluctant to return to the mother's room later in the day or the next day after the father of the child may have visited. Since few are notary publics, clerks may also be unable to complete the paternity affidavit by themselves and must go through the time-consuming step of referring the parents elsewhere to obtain a notarized signature when notarization is necessary. Birth registration clerks may also worry about being unable to answer questions that unmarried parents have about benefits, child support and other implications of the paternity decision. They may also be reluctant to deal with delicate situations that involve both a husband and a putative father. They may resent an added responsibility with no change in their remuneration or support. They may be reluctant to become involved with what they perceive to be a "legal" issue. Due to staff turnover, they may require continual training and oversight to detect training needs. Finally, as hospitals strive to cut costs, some birth registration clerks are being terminated or cut back. Parents are being required to complete all vital statistics forms on their own. This trend may eliminate the possibility for an in-person presentation on paternity and/or any in-person assistance with completing the paternity affidavit.

Hospital Volunteers

The project has used hospital volunteers on a limited basis in the in-hospital paternity effort. Hospital "grandmothers" who volunteer on the postpartum floor have served as translators for paternity workers when presenting the overture to never-married mothers who only speak Spanish. The volatility of many volunteer work schedules and the competing demands placed by hospital staff for their limited time make volunteers of limited utility for in-hospital outreach efforts.

E. Other Obstacles

Public Health Concerns

The most commonly cited concern about introducing the paternity orientation in hospital settings has to do with its implications for the mother's willingness to seek medical care. Many doctors and nurses who work with mothers and babies fear that the paternity intervention will discourage unmarried parents from seeking prenatal care if it is perceived to be a "crack down on deadbeat dads." They are eager to preserve the public view of the hospital as supportive and friendly to poor parents.

The project attempted to allay these concerns by assuring medical and nursing personnel that the paternity establishment process is totally voluntary and confidential. While there are child support implications to paternity establishment, which are disclosed, the two are treated as independent processes. Indeed, under project procedures, paternity affidavits were returned to BVS and were not sent to DDSS. The child support agency refrained from initiating any child support action against fathers until the agency came upon the statement of paternity in its normal course of business.

Although all four hospitals in the Denver project ultimately supported the voluntary acknowledgement procedure, the approach they approved ensured the parents' confidentiality. In some settings where there is automatic reporting of paternity acknowledgements to the child support agency, patient confidentiality may be more of an issue. In these settings, proponents of paternity programs may have to wrestle with the potentially competing goals of gaining hospital support for promoting voluntary acknowledgements in hospital settings and obtaining child support orders most efficaciously by reporting voluntary acknowledgements to the child support agency.

Patient Comfort

It is universally acknowledged that newly delivered mothers are bombarded with information and interruptions during their ever-shrinking hospital stay. Most mothers spend only 24 hours in the hospital after delivering a baby. Hospital staff worry about the ethics and practicality of burdening these mothers during their brief stay with more staff visits, decisions, paper work and information. This is a concern expressed by both supporters and critics of paternity interventions in hospital settings.

Paternal Involvement

Nurses and hospital social workers are ambivalent about unmarried fathers and the impact of paternity acknowledgement programs on their participation and involvement. While some fear that the paternity overture (and its child support implications) will "scare fathers away" from hospitals and undermine "bonding" processes, others worry that the process will empower abusive men and invite participation from men who should be kept at a distance. There is also

concern that current Colorado law does not adequately address the custodial rights of unmarried parents and that mothers who acknowledge paternity may jeopardize their custody status.

Ideological Issues

Frequently, hospital personnel are dubious that paternity establishment will have any practical benefit for babies and mothers. Some staff seem to resent the child support function and do not want to be part of a process they perceive to be primarily designed to reimburse the state for AFDC costs. Indeed, in one hospital, we discovered that one nurse who conducted daily discharge classes routinely advised unmarried mothers not to sign the paternity acknowledgement. Where the project was embraced most readily, the staff tended to support the involvement of fathers, including their assumption of financial responsibility.

Scheduling Prenatal Care

To date, it has been difficult to develop an effective way to make the paternity overture in prenatal settings. Many hospitals use an individual appointment format in the hospital setting or in private doctors' offices. This means that only a nurse or other staff person who normally sees pregnant women for prenatal care must make the paternity overture. Given workload considerations, staff turnover in hospital settings and the diffuse nature of office-based care, these individuals are generally not available for the dissemination of paternity information. Nor is there an efficient way to deploy specialized paternity workers when an individual appointment system is used. Timing is also an issue in programs targeted to the prenatal population. Unless the prenatal overture is made at a single, standard time point, like the first prenatal appointment, there is no practical way to avoid exposing pregnant mothers to program repetitions.

Clinics that use a group format best lend themselves to a group presentation, or a group showing of a video. This is how a paternity outreach with pregnant adolescents was handled at one hospital setting. In another adolescent pregnancy clinic, an attempt to present the paternity overture in the waiting room was abandoned because it was so difficult to get anyone's attention. In still another clinic setting, the hospital was reluctant to include paternity with other educational outreach efforts because it did not want to "offend" married women. It is clearly a challenge to routinely and efficiently reach pregnant, unmarried women and their partners.

Language Barriers

It has been necessary to develop arrangements to overcome language barriers when communicating with the never-married population. More than half of the unwed mothers delivering at Denver's largest public hospital are Latinas; nearly a quarter are Spanish-speaking and do not communicate readily in English. The project has succeeded in making the paternity overture to these women with the assistance of volunteer "grandmothers" on the postpartum floor.

These women are willing to assist the social worker making the overture by translating the information for Spanish-speaking women. Spanish language brochures about the paternity option are also available for distribution. The project developed a Spanish language affidavit that was acceptable to BVS for interpretive purposes only.

Legal Concerns

Until July 1994, the paternity affidavit used in Colorado required a notarized signature for mothers and fathers. In many hospital settings, notary publics are in short supply. Relatively few birth certificate clerks and others who routinely work on the postpartum floor are notary publics. The practical consequence is that unmarried parents often had to hunt for a notary public to complete the affidavit, especially during evening hours when fathers are apt to visit. In addition, one Colorado hospital administrator objected to any hospital employee notarizing a signature on an affidavit for fear of potential hospital involvement in subsequent litigation about paternity. It appears that the substitution of witnessed signatures for notarized ones has resolved many of these problems.

Educational Outreach

Prior to the paternity project, none of the participating hospitals included the issue of paternity in the educational outreach they did with pregnant and newly delivering mothers. As a result of the project, all hospitals have incorporated the issue of paternity in presentations they make to pregnant adolescents. One useful resource is a seven-minute video on the benefits of paternity, and the importance of establishing it at birth, which can be shown individually or to Lamaze class groups or other group settings.

Although paternity education is beginning to be integrated with more pervasive information programs dealing with health and baby care, there continue to be obstacles to its more widespread use. One stumbling block to educational outreach is the fact that, with the exception of hospital programs for pregnant adolescents, there are few services explicitly targeted for unmarried parents. Another obstacle is that paternity continues to be poorly understood by hospital personnel who are frequently new on the job and have not been exposed to specific training on the issue.

F. Summary

Colorado's pilot project has shown that there are many legal, administrative and procedural challenges to be overcome in implementing a program to enhance voluntary acknowledgements in hospital settings. The most important requirement is a simplified, streamlined acknowledgement process. Voluntary paternity acknowledgement forms must be understandable; the process must be fast and free of charge; finally, it is helpful to avoid notarization and to rely on witnessed signatures.

A second necessary ingredient to an effective acknowledgement process is reaching pregnant, and newly delivering, unmarried mothers and their partners in hospital settings. Operating in hospitals requires addressing a host of practical and ideological considerations. This includes the issues of scheduling, language barriers, hospital image, and restrictions on patient contact. Program architects will also encounter a wide variety of reactions by hospital staff ranging from support, to doubt that paternity has any practical value for mothers and babies and to fears that aggressive paternity and child support efforts will discourage unmarried mothers from seeking prenatal care or encourage fathers to visit who are abusive. There are pros and cons to using various types of personnel to make the paternity overture. Finally, prenatal overtures pose particular challenges with respect to timing, scheduling and identifying the relevant target audience. One promising way to present paternity information to pregnant women is to combine it with broader educational outreach efforts dealing with issues like nutrition, labor, delivery and baby care, although there are few programs explicitly targeted to unmarried parents with the exception of adolescent pregnancy programs.

The final component of a successful, in-hospital acknowledgement procedure is a positive relationship between the agencies responsible for child support and birth registration. In-hospital programs will be more successful if personnel in vital statistics and child support agencies cooperate with one another to: develop mutually agreeable paternity acknowledgement procedures and materials; provide training on paternity acknowledgement and its implications to birth registration personnel; and generate timely, hospital-specific performance information on rates of voluntary acknowledgements in order to identify future training needs.

Finally, in order for child support agencies to maximize on the benefits of voluntary paternity acknowledgement and facilitate the process of establishing child support orders, it is also vital that there be an automated interface between the two agencies. Minimally, child support workers should have the capacity to screen birth certificates from their computer terminals in order to distinguish cases which need paternity establishment from those with voluntary acknowledgements.

CHAPTER III

BASELINE RESEARCH: PATERNITY ACKNOWLEDGEMENT IN COLORADO IN 1991

Is in-hospital paternity acknowledgement effective? To answer this question, it is first necessary to generate a baseline portrait of paternity acknowledgement prior to the introduction of hospital-based efforts. We accomplished this in Colorado by commissioning the Department of Health to produce a data tape containing information on the state's 12,668 out-of-wedlock births during 1991. This time period clearly preceded the initiation of project and legislative activities in Colorado aimed at enhancing paternity acknowledgement.

Within the constraints of the data available on the birth statistical abstract file, we conducted an analysis of the characteristics of parents who opted to acknowledge paternity versus their non-acknowledging counterparts. This analysis also examined patterns for the four Denver facilities in which the paternity intervention was subsequently implemented.

A. Highlights from the 1991 Analysis

There were 12,668 out-of-wedlock births in Colorado in 1991. They disproportionately occurred to Latina and African-American women who resided in Denver. Like the nation as a whole, unmarried mothers in Colorado tended to be poorly educated with only 18 percent having more than a high school education. Nearly half (45 percent) had at least one other living child at the time of the 1991 birth.

Father's name was entered on the birth certificate in 23 percent of unmarried births in 1991. Within three years of the birth, another 6 percent had a father's name added as a result of a court order. Overall, the likelihood of a father acknowledging paternity on a voluntary basis increased if the baby was White rather than of minority racial or ethnic status. Similarly, voluntary acknowledgement increased with mother's educational level, her employment during pregnancy, and the absence of prior births. Voluntary paternity acknowledgement did not vary with factors such as maternal age, prenatal care, low birth weight, abnormalities of the newborn or prematurity.

Selected characteristics of unmarried births in Colorado are discussed in greater detail below.

- ❑ The 12,668 out-of-wedlock births in Colorado in 1991 comprised 23.6 percent of the total births in the state for that year.

- ❑ Women with unmarried births ranged in age from 12 to 49 years with an average of 22.7 and a median of 20.5. Over a third of the women were in the 18-21 year range.

- Babies born to unmarried women were primarily White (54 percent), although Latinas (30 percent) and African-Americans (13 percent) were over-represented relative to their distribution in the state's population. In 1991, Whites comprised 73 percent of all Colorado births, while Latinas and African-Americans comprised 18 percent and 6 percent, respectively.

- The average number of years of education for unmarried mothers was 11.5. Only 18 percent of the women had more than a high school education. Approximately 42 percent had less than high school education and the remaining 40 percent had completed high school but had not gone beyond.

- Forty-two percent of the women reported working during at least a portion of their pregnancy. There was not enough information on annual income or occupational category to gain insights on these patterns.

- Approximately a year following the birth, the father's name was entered on the birth certificate in 23 percent of unmarried births in 1991. This included voluntary acknowledgements as well as those achieved by court order. By three years post-birth, the paternity establishment rate had increased to 29 percent. Again, this includes voluntary acknowledgements and court-ordered establishments.

- A few demographic characteristics available from the birth certificate correlated with the presence of the father's name. For example, a name was more likely to be entered if the mother was White (27 percent) rather than African-American (18 percent) or Latina (20 percent). The likelihood of the father's name being entered increased with the mother's years of education. Thus, names were added in 29 percent of the cases where mothers had more than twelve years of education versus 20 percent of the cases where mothers had less than twelve years of education.

- Women who had more than one previous birth were less likely to have the father's name entered (18 percent) than were those women with only one prior birth (22 percent) or no prior births (25 percent).

- There was no indication that entering the father's name on the birth certificate was influenced by prenatal care patterns, low birth weight, abnormalities of the newborn or prematurity.

- ❑ There was little variation in the percentage of cases with the father's name entered on the birth certificate by county of birth or mother's county of residence.

B. Highlights from the 1991 Analyses of the Four Project Hospitals

Colorado's paternity demonstration project was conducted at four Denver area hospitals. These facilities had different voluntary acknowledgement rates prior to the start of the project. In 1991, voluntary acknowledgement rates in participating hospitals ranged from 13 to 24 percent. Within three years, another 11 to 14 percent of unmarried births at each hospital had paternity established by court order.

Not surprisingly, unwed mothers who delivered at these four hospitals had different demographic characteristics that appeared to track with voluntary acknowledgement patterns. In general, the highest voluntary acknowledgement rates occurred at the hospitals with the highest rates of maternal education and employment. Voluntary acknowledgement was also associated with the absence of other living children, and White racial identification. Conversely, hospitals with the lowest voluntary acknowledgement rates tended to have patient populations that were heavily non-White, poorly educated, unemployed and had other previous births.

Rates of voluntary paternity acknowledgement and court ordered establishments at the four participating hospitals in 1991 are presented in Table III-1. Characteristics of the unmarried mothers who delivered at the four project hospitals are summarized in Table III-2. These patterns are discussed below.

- ❑ There were 4,260 unmarried births in 1991 in the four hospitals that participated in the paternity demonstration project: Denver General, Mercy, St. Joseph and University.

- ❑ A comparison of the major facilities in Denver in which the project was subsequently implemented revealed sharp differences in the degree to which the father's name voluntarily appeared on the birth certificate. The lowest rates occurred in Denver General where only 13 percent of unmarried births had a father's name on the birth certificate. At the high end was Mercy, with a voluntary establishment rate of 24 percent.

- ❑ Differences in paternity establishment rates across the participating hospitals appeared to be largely the result of differences in the patient populations that were served. For example, there were significant differences in the average education level of the women served in hospitals participating in the pilot, and education is known to correlate with voluntary paternity establishment. In Denver General Hospital, only 6

percent of unmarried mothers had more than twelve years of education. At Saint Joseph, just over a quarter (26 percent) of the mothers had more than a high school education.

- ❑ Another significant difference in the participating hospitals was the racial profile of mothers delivering out-of-wedlock babies. At University and St. Joseph Hospitals, 49 and 44 percent, respectively, were White. At Mercy, the proportion of Whites was 24 percent. And at Denver General, the proportion of Whites was only 12 percent. Mercy had the highest proportion of African-American women (37 percent). Delivering mothers at Denver General were overwhelmingly Latina (61 percent).

- ❑ Unmarried mothers delivering at the four project hospitals had significantly different employment patterns during pregnancy with 53 percent reporting employment at St. Joseph compared with 20 percent at Denver General. These differences persisted even when we restricted the analysis to mothers aged 19 years or more.

- ❑ Unmarried mothers delivering at the four project hospitals had different numbers of prior births. Mothers at Denver General Hospital were significantly more likely to have other living children (57 percent) than their counterparts at St. Joseph (35 percent) and University (49 percent).

- ❑ There were no significant differences in the average age of unmarried mothers delivering at the four participating hospital sites. Across all four sites it was 22.3 to 22.8 years.

Table III-1
Voluntary Paternity Acknowledgement Rates and Court Orders in Project Hospitals in 1991 Prior to the Demonstration

Hospitals	Paternity Established Via		Paternity Not Established	Numbers of Unwed Births
	Voluntary Acknowledgement	Court Order		
Denver General	13%	14%	73%	1,697

Mercy	24%	12%	64%	87
St. Joseph	20%	12%	68%	1,290
University	22%	11%	67%	1,186
State Total	**23%**	**6%**	**71%**	**12,668**

Table III-2
Selected Characteristics of Unwed Mothers
Delivering in Four Project Hospitals (1991)

Hospitals	Average Age of Mother	% Less than 12 Years Education	% Employed During Pregnancy	% With Other Living Children	% White	Numbers of Unwed Births
Denver General	22.3	66%	20%	57%	12%	1,697
Mercy	22.8	40%	37%	51%	24%	87
St. Joseph	22.5	25%	53%	35%	44%	1,290
University	22.7	45%	48%	49%	49%	1,186

C. Summary

An analysis of 1991 births to unmarried mothers in Colorado revealed that the father's name was voluntarily placed on the birth certificate in 23 percent of the cases within the first year of the baby's life. Within three years following delivery, the proportion of establishments stood at 29 percent. Voluntary paternity acknowledgement was correlated with certain demographic characteristics of the mother. This included ethnicity, education and numbers of prior births. Paternity was more apt to be acknowledged voluntarily among White mothers, educated mothers, and mothers with no or only one prior birth.

These patterns are reflected in the demographic profile of unmarried mothers who delivered at the four participating hospitals in the paternity demonstration project. In 1991, prior to the start of the demonstration project and the initiation of routine, in-hospital presentations about paternity, voluntary acknowledgement rates ranged from 13 to 24 percent at project hospitals. These rates varied with the educational, racial and employment profile of the unmarried populations served at each facility. The lowest voluntary acknowledgement level occurred at the hospital site with the highest proportion of mothers who were: non-White; poorly educated; had many prior births; and the lowest levels of employment during pregnancy. Conversely, acknowledgement levels were significantly higher at hospitals where mothers were more apt to have at least attended high school, worked during pregnancy, and had fewer numbers of prior births.