

Process Evaluation of the Bright Start Demonstration Program's Implementation

State of Washington
Department of Social and
Health Services

ECONorthwest

ECONOMICS • FINANCE • PLANNING

888 SW Fifth Avenue
Suite 1460
Portland, Oregon 97204
503-222-6060
www.econw.com



The LEWIN GROUP

3130 Fairview Park Drive
Falls Church, VA 22042
703-269-5528

Table of Contents

CHAPTER 1 – INTRODUCTION AND SUMMARY	1-1
Washington’s Paternity Affidavit program	1-1
Bright Start demonstration.....	1-2
Purpose of this report.....	1-4
Summary of Findings	1-4
Existing Conditions.....	1-4
Bright Start Implementation	1-6
CHAPTER 2 – CURRENT PATERNITY ESTABLISHMENT PRACTICES.....	2-1
Overview of paternity establishment in child support enforcement.....	2-1
Origin of Washington State’s Paternity Affidavit program	2-3
Implementation of the affidavit program.....	2-5
Program conditions and performance	2-6
Current practices in paternity establishment.....	2-9
Barriers to voluntary paternity establishment.....	2-20
Court-based establishment.....	2-26
CHAPTER 3 – BRIGHT START IMPLEMENTATION AND PERCEPTIONS	3-1
Overview of Bright Start	3-1
Bright Start Implementation	3-3
Updated Paternity Materials	3-4
Dispute Resolution Centers	3-4
Marriage Education Providers.....	3-6
Genetic Testing	3-7
Other Community Partners	3-8
Reactions to Bright Start	3-8

Hospitals	3-8
DCS Field Offices.....	3-11
Dispute resolution centers	3-11
Marriage education providers	3-12
Prosecuting Attorneys	3-12
CHAPTER 4 –CONCLUSION.....	4-1
Conclusion.....	4-1
Current Practices	4-1
The Bright Start Demonstration Project.....	4-2
Next Steps	4-2

WASHINGTON'S PATERNITY AFFIDAVIT PROGRAM

In the late 1980s, Washington State greatly expanded the use of voluntary Paternity Affidavits and made them available in hospitals and other medical facilities. The model was recognized as a national best practice and, in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), the U.S. Congress required that every state implement a voluntary paternity establishment program based on Washington's model.

Today, more than 15 years after Washington State created its Paternity Affidavit program, hospitals generate 70 percent of the voluntary paternity acknowledgements in the state, establishing paternity for 44 percent of births to unwed mothers.¹ By most accounts, the program is a huge success; however, variations in performance persist across the state. In 2003, in-hospital rates of voluntary paternity establishment ranged from 8 to 77 percent for hospitals with between 20 and 500 births to unmarried mothers, and from 15 to 68 percent for hospitals with over 500 such births.² While varying demographic and economic conditions may explain some of the performance difference, the Washington State Department of Child Support (DCS) officials believe hospitals' approaches to program implementation also play a role.

To strengthen the program, the state applied for and received a grant from the Federal Office of Child Support Enforcement (OCSE) to implement the Bright Start demonstration program. Bright Start seeks to reinvigorate and expand the services associated with the voluntary Paternity Affidavit program. As a condition of the grant, DCS must evaluate the demonstration. DCS contracted with ECONorthwest, and its subcontractor, The Lewin Group, to conduct an implementation and outcome study. This report is the first process study; it documents the history of Washington's Paternity Affidavit program, existing program conditions, and early implementation successes of, and challenges for, the Bright Start model. Future reports will focus on continued program implementation and outcomes.

The Washington State Paternity Affidavit Program began in July 1989 as a partnership between DCS and the Washington State Department of Health (DOH). The program provides cooperative unmarried parents an opportunity to sign a Paternity Affidavit at the child's birth or shortly thereafter. The program works on the assumption that a majority of unmarried fathers are present at the hospital at the time of their child's birth. The program's founders believed this would be an opportune time to discuss the rights and responsibilities of establishing paternity. Nurses, social workers, midwives, medical records workers, or other authorized hospital employees provide unmarried parents an opportunity to sign a Paternity Affidavit at their child's birth. A properly filed Paternity Affidavit immediately creates a legal finding of paternity.

¹ Based on data from 2003, the most recent available. Total voluntary paternity acknowledgements accounted for 63 percent of all unmarried births and 53 percent of all paternities established. Many were established for children born in prior years.

² Four hospitals had between one and 20 births to unmarried mothers in 2003, and their paternity establishment rates ranged from 0 to 117 percent. These rates are not, however, particularly meaningful because of the small number of births and because affidavits may be recorded for a child born in a prior month.

From the father's perspective these rights include establishing a legal and permanent tie to his child and ensuring his name appears on the child's birth certificate, facilitating subsequent establishment of visitation and custody rights. From the child's perspective, obtaining Social Security or veteran's benefits, life insurance, and inheritance from the father requires paternity establishment, as can accessing information about the father's health history. From the mother's perspective, paternity establishment is the first step in obtaining a child support order.

From DCS's perspective, the hospital paternity establishment program:

- **Expedites the identification of unwed fathers.** Prior to the hospital program, DCS may have initiated paternity establishment efforts months, or even years, after a child's birth. As time passes, the unwed parents may move, lose contact with one another, or enter relationships with other people. As time passes, the probability of successfully establishing paternity falls and the cost of each successful establishment increases.
- **Reduces the number of adversarial court proceedings.** Prior to Washington's voluntary affidavit program, state courts were the primary venue for establishing paternity. Formal court proceedings, by their nature, tend to be intimidating, adversarial, and inherently unpleasant for most parties involved.
- **Saves taxpayer dollars.** The signed Paternity Affidavit allows DCS to establish a child support obligation quickly and at low cost. Usually, DCS obtains a child support order within 90 days or less from the date DOH files the Paternity Affidavit. Total DCS administrative costs total less than \$150 per case compared with a DCS-estimated \$1,600 per case when a prosecuting attorney is involved. DCS estimates that the Paternity Affidavit program saves the taxpayers more than \$5 million yearly.

BRIGHT START DEMONSTRATION

In mid-2005, OCSE awarded Washington State an 1115 demonstration grant to implement and rigorously evaluate enhancements to its pioneering work in voluntary paternity establishment. Specifically, the demonstration, called the Bright Start Program, seeks to mitigate the existing barriers to voluntary establishment through two major strategies.

Strategy 1: Strengthen delivery of the existing features of the voluntary paternity establishment program. To reduce the barriers to voluntary establishments and improve paternity establishment rates at low-performing hospitals, DCS is implementing the following strategies in four demonstration regions:³

- **Recruit and train additional hospital-based notaries.** DCS officials note that inconsistent availability of notaries, who are required to verify the identity of affidavit signers, affects paternity establishment rates.

³ The four Bright Start demonstration regions are Fife, Tacoma, Vancouver, and Yakima. The six control regions are Everett, Kennewick, Olympia, Seattle, Spokane, and Wenatchee.

- **Target recruitment of hospital-based social workers to serve as the key hospital-based coordinators of the affidavit program.** DCS recognizes that nurses and other medical staff in hospitals are primarily concerned with the immediate health and wellbeing of the mother and child and may not have time to focus on Paternity Affidavits.
- **Update DCS’s paternity establishment video and information booklet.** DCS currently encourages all hospitals to show parents a video that explains the benefits and responsibilities inherent in signing a Paternity Affidavit. As part of the demonstration, DCS will update the paternity information distributed to parents and purchase televisions, VCR/DVD players and rolling carts for hospitals that need them.
- **Expand partnerships with non-hospital community partners.** DCS is actively seeking participation from entities that have contact with unmarried parents. These entities include, but are not limited to local welfare offices, Head Start programs, WIC programs, health clinics, and prosecuting attorneys.

Strategy 2: Expand the range of services associated with the Paternity Affidavit program. In addition to improving delivery of the existing program, DCS will expand the range of services associated with voluntary paternity process. Specifically, the Division will:

- **Offer no-cost genetic testing for parents who do not sign the Paternity Affidavit at the hospital.** For some parents, the key barrier to signing the affidavit is a lack of certainty about paternity. As part of the demonstration, DCS will pay the cost for a genetic test at the state rate of about \$126 (the private sector rate is about \$600). Parents will receive the test results and determine whether or not to sign the affidavit.
- **Offer no-cost marriage education services.** DCS developed an information booklet and video to refer interested unwed parents to a local marriage education course. This service is available only to parents who sign the affidavit.
- **Offer services to develop a parenting plan.** DCS contracted with Dispute Resolution Centers in three of the four target regions to provide parenting plan services to interested parents who have signed a Paternity Affidavit. These plans—legally binding documents when filed with the courts—address access and visitation, among other issues.

By strengthening and enhancing the program, DCS expects to record a measurable increase in the rate of voluntary paternity establishment, resulting in a corresponding decrease in the number of expensive court-ordered paternity establishments. This would free court docket time and save public resources. Cases beginning with a voluntary paternity acknowledgement are handled administratively, rather than judicially. DCS believes the administrative process expedites the timing of order establishments, improves payment rates for current support, and mitigates the accrual of arrears.

PURPOSE OF THIS REPORT

This report represents the first phase of a process study and documents the implementation of the Bright Start program. The study documents Washington's existing in-hospital paternity establishment program and compares practices across the state, offering insights into why voluntary rates of establishment vary from place to place. Through interviews with hospital staff and state-and field-level DCS officials, the study explores factors that facilitate high rates of voluntary paternity establishment in some areas and lower rates in others.

After a thorough documentation of the origins, evolution, and existing condition of Washington's Paternity Affidavit program, the study turns to a description of Bright Start's initial implementation. At the time of publication (June 2006), DCS had introduced the Bright Start Program to staff in 17 birthing hospitals in the four demonstration regions.⁴ The state successfully developed materials, contracted with local and national agencies to provide the expanded services, and provided an introductory training to hospital staff. Staff encountered implementation challenges including an absence of operational marriage education programs in all four demonstration regions and of dispute resolution mediators in the Vancouver area.

This first phase of the process study forms the foundation of the project's evaluation, which—at the program's conclusion—will include a complete description of Bright Start processes, from implementation through the demonstration's conclusion, an impact study that will estimate the independent effect of Bright Start on rates of voluntary paternity establishment, and a participation study that measures demand for the program's enhanced services (i.e., genetic testing, dispute resolution, and marriage education).

SUMMARY OF FINDINGS

EXISTING CONDITIONS

- **Voluntary paternity establishment rates continue to improve.** The ratio of Paternity Affidavits filed to unmarried births increased from 50 percent in 1996 to 62 percent in 2004. More recent data suggest further improvements, as the state continues to exceed federal paternity establishment benchmarks.
- **Voluntary paternity establishment rates vary considerably across DCS regions.** In 2003, the ratio of Paternity Affidavits to unmarried births ranged from 57 to 67 percent across the ten DCS regions. In-hospital affidavits were submitted for between 31 and 53 percent of births to unmarried parents in each region.
- **Opposition to the Paternity Affidavit program is limited.** Few hospital staff voiced complaints or concerns about the Paternity Affidavit process, and DCS staff stated that the Prosecuting Attorneys Offices—which handle judicial paternity cases in Washington—generally support the program.

⁴ One site, Bremerton Naval Hospital, received an abbreviated training due to personnel changes. The Bright Start manager scheduled an additional, more comprehensive training for when the necessary staff could be present.

However, prosecuting attorneys in one region and some hospital staff expressed opposition to the program.

- **Some prosecutors believe the program undermines parents' rights to due process.** In their opinion, unwed parents are given insufficient information about the rights and responsibilities of fatherhood before signing the affidavit and, by signing, are precluded from related legal services that establish parenting and visitation plans. Some prosecutors also believe the program has insufficient safeguards to prevent people from falsely signing an affidavit as a costless alternative to legal adoption.
- **A limited number of hospital medical staff stated that the program is a distraction from their key mission: securing the health of mother and child.** Moreover, some hospital administrators have been uncomfortable deploying staff to notarize legal documents.
- **The Paternity Affidavit program operates with little intervention from DCS.** During the 1990s, an Olympia-based manager oversaw the implementation and execution of the Paternity Affidavit program. The early years of the program saw periodic reports regarding implementation and best practices, as well as site visits. Beginning in 1995, responsibility for the program fell to the state's 10 field offices. In 2006, the program essentially runs itself with hospitals ordering affidavit forms and handbooks as needed.
- **Methods for introducing the affidavit to unwed parents vary significantly across hospitals.** Some hospitals directly link the paternity discussion to the birth certificate paperwork (Washington will not list a father on the official birth certificate without established paternity), other hospitals refuse to include the father's name on "souvenir" birth certificates unless the father has acknowledged paternity. In some locations, parents receive paternity information as part of a standard informational packet that includes a range of documents including baby photography forms, information about post-natal health classes, and coupons for baby products. At one hospital, affidavits were distributed only to unwed parents who asked for paternity information.
- **Demographic characteristics of the patient population drive hospitals' paternity establishment rates.** Rural hospitals often face significant communication barriers to securing affidavits from immigrant populations. Hospital staff suggest age and maturity play an important role in whether a father decides to sign an affidavit.
- **Shortened hospital stays challenge voluntary establishments.** Most hospital staff agreed that the duration of birth-related hospital stays have shortened over time with some patients discharged in as little as 24 hours. Brief stays leave less time for hospital staff to introduce and appropriately discuss the paternity issue.
- **Absent fathers limit the program's reach.** Hospital staff cited the absence of the biological father at the hospital as a key factor limiting voluntary paternity establishment. The most important causes for absence include incarceration, immigration status, military deployment, and age.

- **Availability of notaries varies across hospitals.** Hospital staff generally agreed with the state’s hypothesis that the number of notaries—and their availability throughout discharge hours—was a key driver of the number of affidavits signed. Hospitals expressed a need for additional notaries to cover weekend hours and to cover periods when existing notaries were otherwise occupied or on vacation.
- **Notary identification standards vary.** Interviews with hospital staff who serve as notaries suggested that identification requirements are not implemented uniformly across the program. Some staff accept identification issued by foreign governments, others accept only US-issued ID, and yet others would accept only identification issued by Washington State. Identification requirements used by some notaries are clearly more restrictive than allowed in Washington statute.⁵

BRIGHT START IMPLEMENTATION

- **Hospitals welcome offer of notary training.** During the state’s Bright Start training visits, hospitals indicated the need to train at least 40 additional staff members to serve as notaries and applauded the state’s willingness to underwrite the associated fees.
- **Revised video and related equipment viewed favorably by hospital staff.** Staff interviews suggested that few hospitals routinely show parents the state’s existing Paternity Affidavit video. Staff pointed to wall-mounted televisions, with no connections to VCR or CD players, as a key barrier and welcomed the addition of televisions, VCR/DVD players and rolling carts. Other staff indicated that, despite its relatively short length, they would continue to have difficulty finding time to show the video during a mother’s hospital stay.
- **Hospital staff believe genetic testing relevant and relatively straightforward to implement.** Hospital staff universally embraced the concept of offering free genetic testing to parents. Virtually all staff interviewed had encountered couples that were unwilling to sign an affidavit because of lingering questions about the identity of the biological father. Compared to the other enhanced services, genetic testing services were relatively easy to organize and implement. In very small communities where the state’s genetic-testing vendor lacked partner facilities, the birthing hospitals offered to conduct the tests.
- **Hospital staff support other enhancements but are skeptical of take-up rates.** Hospital staff thought that parenting plans and marriage education classes were a good idea, but questioned whether new parents, especially younger ones, would take advantage of them. Both involve time

⁵ Wash. Rev. Code §42.44.080(8) states that “A notary public has satisfactory evidence that a person is the person described in a document if that person: (a) Is personally known to the notary public; (b) is identified upon the oath or affirmation of a credible witness personally known to the notary public; or (c) is identified on the basis of identification documents. Wash. Admin. Code §308.30.155(1) defines acceptable identification documents as “Current documents issued by a federal or state government with the individual’s photograph, signature, and physical description.”

commitments and an ability to travel, significant barriers for many parents. Additionally, new parents may be in a “honeymoon” period and do not anticipate a need for marriage education or parenting plans. Hospital staff predicted that these services would be more popular as time goes on and couples experience relationship problems,

- **Aspects of the Bright Start program will expand to meet demand from DCS field offices and other community partners.** Bright Start expands support for hospital-based paternity establishment. DCS employees have expressed interest in also offering Bright Start services, and numerous other organizations could play an increased role in paternity establishment. Hospital staff suggested that prenatal clinics and programs for young unmarried parents could increase the rate of voluntary paternity establishment.

Current Paternity Establishment Practices

OVERVIEW OF PATERNITY ESTABLISHMENT IN CHILD SUPPORT ENFORCEMENT

Paternity establishment is the foundation of child support enforcement. Without it, a biological father has no legal responsibility to provide financial support to his child. In addition to financial benefits, child advocates argue that paternity establishment can also provide emotional, social, and psychological benefits. Finally, knowing a biological father's medical history is sometimes crucial to providing medical care to his child.

In response to a significant increase in non-marital births, Congress enacted five key laws to strengthen and expedite paternity establishment processes:

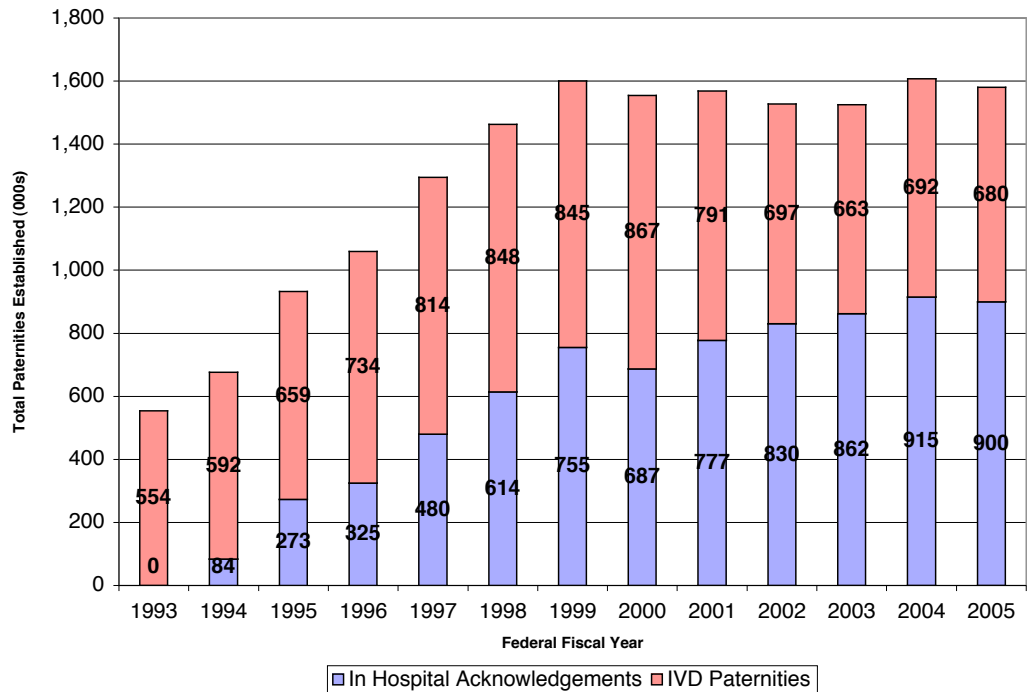
- **Child Support Amendments of 1984** required States to initiate paternity establishment for all children under age 18, including for children whose cases were previously dismissed because a lower age limit was in place.
- **Family Support Act of 1988** encouraged states to create simple, administrative procedures for contested paternities. The law also required States to order genetic testing upon the request of any party and provided federal fund (90 percent match) to pay for the tests.
- **Omnibus Budget Reconciliation Act of 1993 (OBRA)** required States to create simple civil processes through which biological fathers could voluntarily acknowledge paternity during the period immediately preceding or following the birth of a child, including an in-hospital program. The law also required States to afford adequate due process and explain the rights and responsibilities of acknowledging paternity. Regarding genetic testing, the law established methods for individuals to object to test results and required States to create a rebuttable or conclusive presumption of paternity if results exceeded a threshold probability of the alleged father's being the father of the child. Finally, the law created performance standards for States—a 75 percent establishment rate—that were backed up by financial penalties.
- **Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)** increased the performance goal from 75 to 90 percent, required a uniform affidavit for men voluntarily acknowledging paternity and entitled the affidavit to full faith and

credit in any State, and stipulated that a signed acknowledgment of paternity be considered a legal finding unless rescinded within 60 days or thereafter challenged in court on the basis of fraud, duress, or material mistake of fact. PRWORA also required the Department of Health and Human Services Secretary to develop a performance-based, revenue-neutral incentive system in collaboration with state CSE directors.

- **Child Support Performance and Incentive Act of 1998 (CSPIA)** created an incentive system that tied payments to state performance in five areas deemed crucial to effective child support programs, including paternity establishment.

While all five laws were instrumental in shaping the methods by which States establish paternity today, OBRA’s focus on in-hospital acknowledgements revolutionized the establishment process. The federal law was modeled on Washington’s 1989 statute requiring physicians, nurses, midwives, and hospitals to provide an opportunity for biological fathers to voluntarily acknowledge paternity around the time of the child’s birth. The in-hospital program is credited with increasing voluntary establishment. Between 1993 and 1999, the annual number of paternities established increased from 554,000 to 1.6 million (see Figure 2-1). During the early 2000s, the number of in-hospital paternities has continued to grow, but total paternities established have stabilized between 1.5 and 1.6 million annually.

Figure 2-1: Number of Paternities Established Nationally by Method, Federal Fiscal Year 1993-2005 (in Thousands)



Source: US Office of Child Support Annual Reports to Congress, Various Years

The remainder of this chapter focuses on the creation and implementation of Washington State’s voluntary Paternity Affidavit program. It also compares voluntary establishment processes to court-based methods and assesses the performance of Washington State’s paternity establishment efforts.

ORIGIN OF WASHINGTON STATE’S PATERNITY AFFIDAVIT PROGRAM¹

In the late 1980s, federal and state governments were seeking ways to reduce the cost of the welfare program then known as Aid to Families with Dependent Children (AFDC). Policymakers viewed child support enforcement programs as key to curbing growing welfare costs. When a state successfully established and collected on AFDC-related child support cases, the state retained the majority of child support payment to reimburse itself—and the federal government—for current and past AFDC payments.

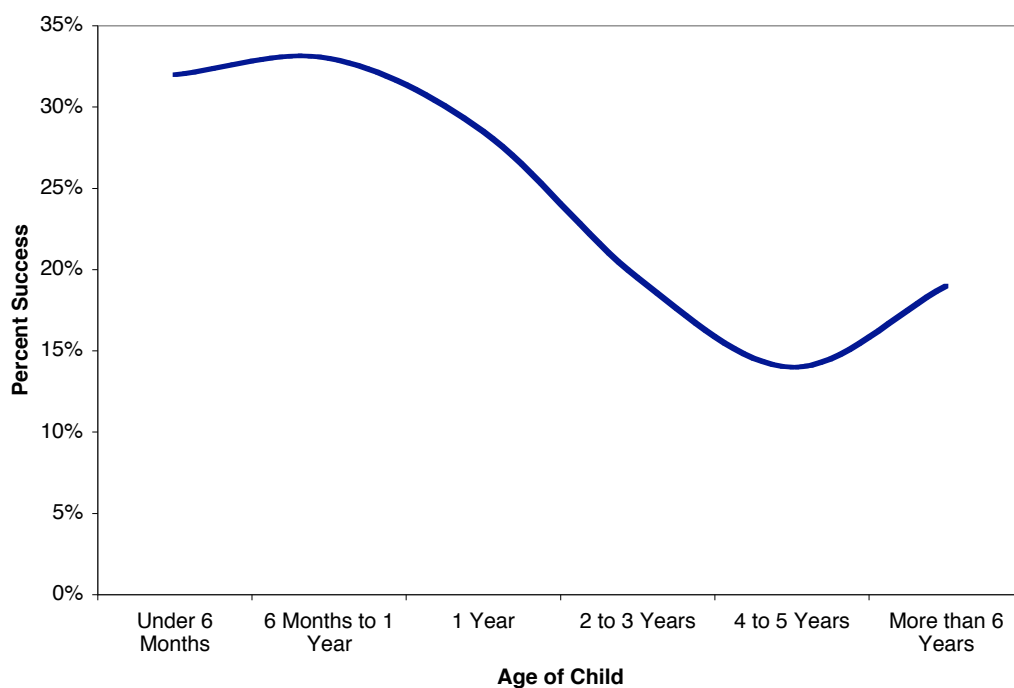
The first step in a child support case is paternity determination, which establishes the legal link between a biological father and his child. During the mid- to late-1980s, the number of unmarried births was rising in Washington and elsewhere and, as a consequence, 40 percent of Washington State’s new cash welfare cases required a paternity determination.

As the demands for paternity establishment grew, a federal audit concluded that Washington State was not pursuing all paternity cases equally and was essentially avoiding work on harder cases. Soon after the release of the federal audit, the Washington State Commission for Efficiency and Accountability in Government (hereafter, the Commission) reviewed the state’s paternity establishment practices. Commission members visited six county prosecutors and identified the inability to locate the absent parent and unwillingness of the mother to cooperate as the two key barriers to successful paternity establishment.

In addition, the team reviewed sample cases in an attempt to identify a relationship between the age of a child and successful paternity establishment. Analysts estimated the odds of successfully establishing paternity for a child under age 1 exceeded 30 percent. For children aged 4 or older, the odds of a successful paternity action fell below 20 percent (See Figure 2-2).

¹ This section draws heavily from The Washington State Commission for Efficiency and Accountability in Government. September 1988. *Office of Support Enforcement Study: Final Draft Report*. Olympia, WA.

Figure 2-2: Paternity Establishment Success Rate by Age of Child, 1988



Source: Governor Gardner's Efficiency Commission, 1988

From these data, the Commission concluded that the state should make a special effort to establish paternity as early as possible in a child's life. It also noted that state officials were essentially ignoring 4,000 voluntary affidavits signed annually in which fathers swore to paternity, a number equal to 29 percent of unmarried births at the time. The Commission recommended that the voluntary affidavits should serve as a formal method of paternity establishment—assuming parents are given appropriate notice of rights and responsibilities and are given opportunities to take blood tests. Finally, and most importantly, the Commission called for the resolution of the paternity subject *at the hospital* shortly after birth.

Final recommendations called on policymakers to:

- Modify the forms used to acknowledge parentage to contain sworn statements by both parties that they are the biological parents, an explanation of the parental rights and responsibilities;
- Amend state law to provide that the natural parents may establish paternity, by operation of law, by signing and filing the official acknowledgement form;
- Amend state law to require Social Security numbers on birth certificates;
- Develop a booklet that describes the consequences of signing an acknowledgement form; and

- Develop a reimbursement system to pay hospitals and the state office of vital records for distributing and processing the forms.

The Commission estimated that 50 percent of fathers accompany mothers at the hospital and that 80 percent of those fathers present at the hospital would sign an affidavit. Put differently, the Commission anticipated paternity would be established at the hospital for 40 percent of unmarried births.

IMPLEMENTATION OF THE AFFIDAVIT PROGRAM

Lawmakers enacted the Commission's recommendations in less than a year. Effective July 23, 1989, the state's Paternity Affidavit statute (Wash. Rev. Code §70.58.080) required:

- Physicians, midwives and hospitals to provide an opportunity to sign an affidavit;
- Physicians, midwives, and hospitals to provide written materials outlining the consequences of signing the affidavit;
- Hospitals to add the father's name to the birth certificate within ten days of the birth and to forward the completed affidavit to their local registrar.

In the early 1990s, the state estimated 98 percent of births took place at one of 79 birthing hospitals. The state initiated a training program and disseminated affidavit forms and a related "Parental Rights and Responsibilities" brochure. During 1989-1993, DCS and DOH staff conducted on-site trainings in 50 hospitals and distributed periodic progress reports.

As of April 1993, 70 out of 79 eligible hospitals were participating in the program. Of the nine non-participating hospitals, only two were of significant size. The number of affidavits submitted during the program's initial years climbed from 6,500 in 1990 to more than 10,000 in 1992. The number of affidavits received by participating hospitals correlated broadly to their number of unmarried births, but the state did not conduct in-depth analyses to explore why some hospitals appeared to outperform others

From the program's outset, affidavit-processing times satisfied program officials. In 1990, DCS received the typical Paternity Affidavit from hospitals 36 days after the child's birth. By 1992, the typical delay shrank to 27 days.

In a 1993 case review, DCS estimated that more than three-quarters of signing parents cohabitated at the time of the child's birth. DCS also found 41 percent of the children associated with the affidavits were, or had been, enrolled in AFDC.

By nearly all measures, the in-hospital paternity establishment program started with broad participation and relatively few objections. The program's chief detractors were county-based prosecuting attorneys who run the parallel, court-

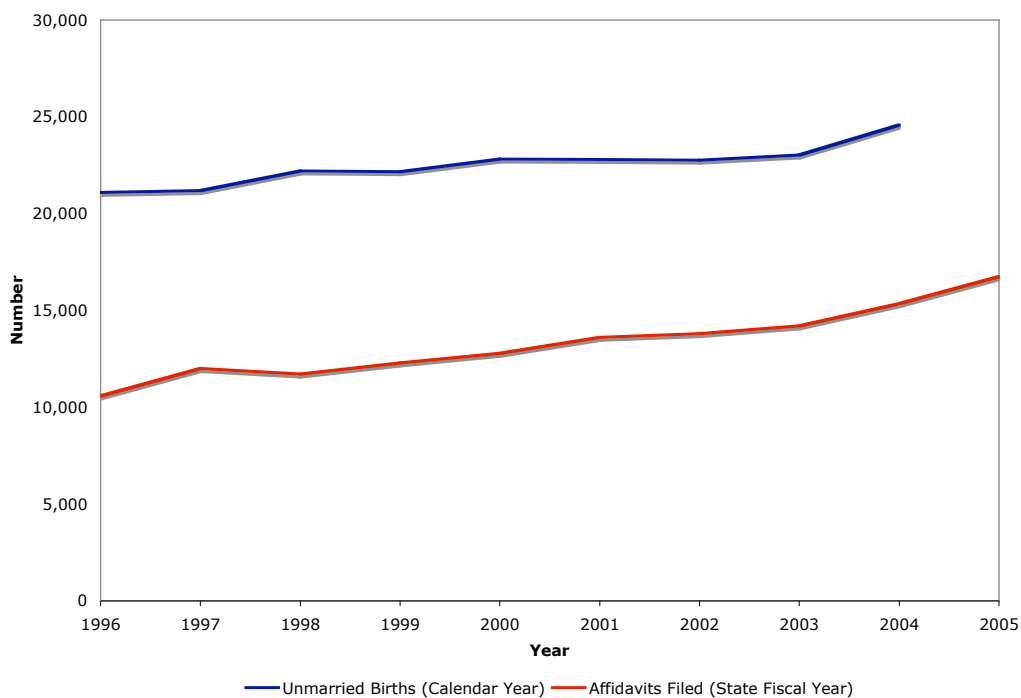
based paternity establishment system. Their objections, which persist to a lesser extent today, center on concerns about inadequate due process and inadequate safeguards against false affidavits. In short, some prosecuting attorneys argued that hospital-based staff have neither the time nor the expertise to fully explain the rights and responsibilities associated with the signed affidavit. Moreover, they suggested staff did not adequately discourage or prevent people from falsely attesting to paternity, which some companions may have viewed as an inexpensive alternative to formal adoption. Finally, by signing an affidavit, parents lost access to a court-based process that—in addition to paternity establishment—addresses visitation and custody issues.

On occasion, some medical professionals have expressed concerns about the affidavit program. Some physicians and nurses argue the program’s purpose does not fall within their primary mission: maintaining the health of mother and child. In addition, one hospital’s administrators were generally unwilling to have hospital staff notarize legal documents because of potential liability issues.

PROGRAM CONDITIONS AND PERFORMANCE

The number of voluntary paternity acknowledgements filed with the State has increased along with the number of births to unmarried mothers, as illustrated in figure 2-3.

Figure 2-3: Number of Unmarried Births and Paternity Affidavits Filed in Washington, 1996-2005

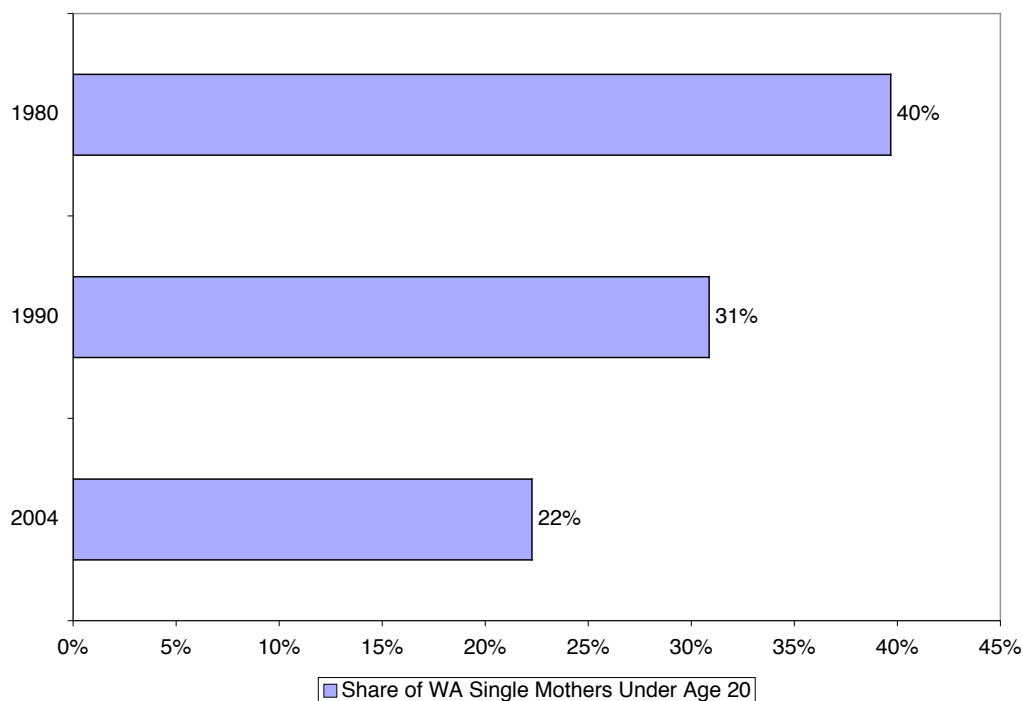


Source: Washington State DCS and DOH

During a similar period, the ratio of affidavits filed to the number of unmarried births rose from 50 percent to 62 percent, illustrating the increasing importance of the affidavit.

The share of single mothers under age 20 has fallen dramatically over the past 25 years as demonstrated in Figure 2-4. The number of births to unmarried women over age 20 has increased correspondingly. This shift towards older, presumably more mature, unmarried mothers may explain the increasing number affidavits received and suggests an increasing role for the Paternity Affidavit program in the future if this trend continues.

Figure 2-4: Proportion of Single Mothers Under Age 20

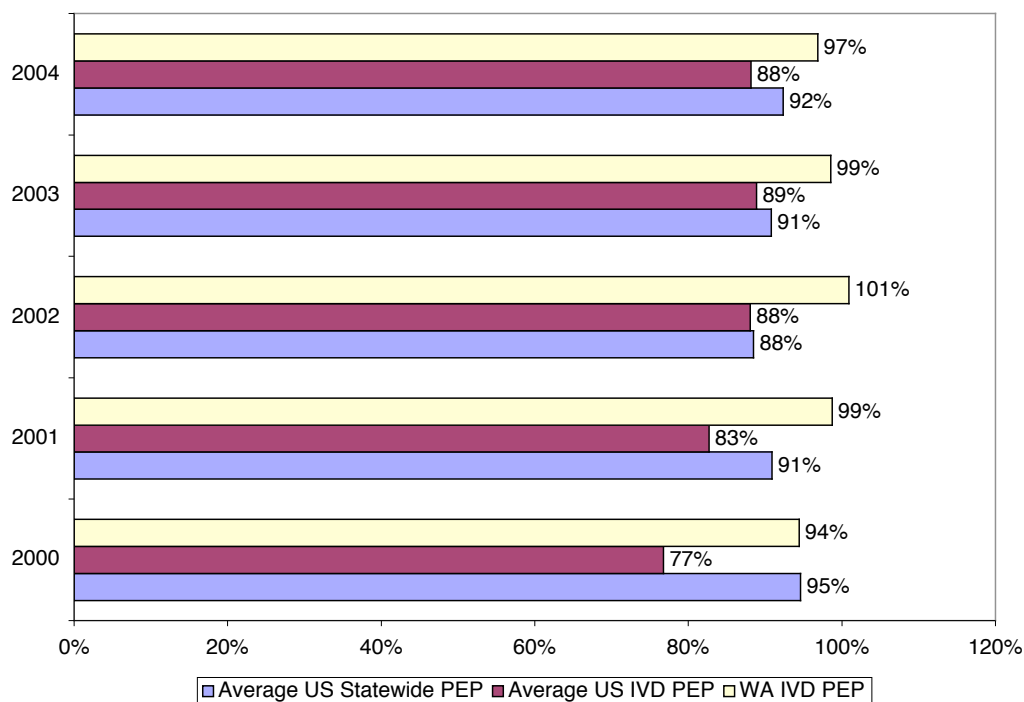


Source: Washington State DOH

Under CSPIA, paternity establishment rates are one of five performance measures the federal government uses to judge and financially reward program quality. To receive 100% of the incentive payment for paternity establishment, states must establish paternities for 90% of cases. States have the option of using one of two paternity establishment definitions: paternity establishment in the IV-D caseload or paternity establishment among all non-marital births statewide. Washington and 24 other states use the IV-D definition.

Figure 2-5 shows Washington has exceeded the 90 percent federal standard every year since Federal Fiscal Year (FFY) 2000 and has generally performed above the US average—regardless of the definition.

Figure 2-5: Paternity Establishment Percentages, Washington State and US Averages, Federal Fiscal Years 2000-2004



Source: US Office of Child Support Enforcement

Although the state as a whole regularly exceeds federal benchmarks, hospital-based voluntary paternity establishment rates vary considerably across DCS regions, from 31 percent in the Vancouver region, to 53 percent in the Spokane region.² The variation within regions is even greater. In the Vancouver region, for example, establishment rates range from 15 to 70 percent. Table 2-1 lists the number of Paternity Affidavits filed by each of Washington’s birthing hospitals in 2003, expressed as a percentage of unmarried births.³

² The PEP ratios displayed in Figure 2-5 above are calculated using all types of paternity establishment, including judicial establishments and voluntary acknowledgements from sources other than hospitals.

³ Filing does not necessarily occur in the month of a child’s birth, so percentages greater than 100 percent are possible.

Table 2-1: Paternity Establishment Percentages, Washington State and US Averages, Federal Fiscal Years 2000-2004

Provider Name	Affidavits Filed	Provider Name	Affidavits Filed	Provider Name	Affidavits Filed
Everett		Olympia		Tacoma	
Valley General	56%	Olympic Memorial	60%	Harrison Memorial	61%
Cascade Valley	56%	Grays Harbor Community	59%	Tacoma General	44%
Stevens Memorial	56%	Providence St. Peter	54%	St. Clare	29%
St. Joseph - Bellingham	54%	Jefferson General	50%	Naval - Bremerton	19%
Providence General	47%	Capital Medical Center	47%	Tacoma Total	47%
Whidbey General	47%	Mason General	43%	Vancouver	
Island Community	38%	Forks Community	33%	Willappa Harbor	70%
Skagit Valley	37%	Morton General Hospital	33%	St. John	69%
Naval - Whidbey Island	36%	Providence - Centralia	20%	Skyline	58%
Everett Total	49%	Olympia Total	48%	Klickitat Valley	42%
Fife		Seattle		SW Washington Med Ctr	15%
St. Joseph - Tacoma	43%	Swedish - Ballard	76%	Vancouver Total	31%
Good Samaritan	42%	Evergreen Hospital	68%	Wenatchee	
St. Francis	42%	Overlake Community	66%	Okanogan-Douglas Hosp	77%
Enumclaw Community	35%	Valley Medical Center	65%	Quincy Valley Hospital	75%
Madigan Army Med Ctr	32%	Northwest Hospital	55%	Coulee Community Hosp	56%
Auburn Regional	30%	Highline Community	46%	Othello Community Hosp	55%
Fife Total	40%	Swedish Medical Center	44%	Mid-Valley Hospital	51%
Spokane		Group Health Central	33%	Samaritan Hospital	46%
St. Joseph - Cheweleh	117%	UW Medical Center	29%	North Valley Hospital	33%
Deaconess Medical Ctr	66%	Seattle Total	51%	Lake Chelan Hospital	31%
Newport Community	63%	Kennewick		Central WA Hospital	20%
Pullman Memorial Hosp	61%	Kadlec Hospital	56%	Wenatchee Total	41%
Valley Hospital	55%	St. Mary Medical Center	54%	Yakima	
Mount Carmel Hospital	54%	Walla Walla General	40%	Kittitas Valley	65%
Holy Family Hospital	53%	Lady of Lourdes Hospital	29%	Topenish Community	46%
Whitman Hospital	42%	Kennewick General	23%	Yakima Valley Memorial	39%
Sacred Heart Hospital	34%	Prosser Memorial	8%	Sunnyside Community	38%
Lincoln Hospital	0%	Kennewick Total	35%	Grand Total	45%
Ferry County Hospital	0%				
Spokane Total	53%				

Source: US Office of Child Support Enforcement

CURRENT PRACTICES IN PATERNITY ESTABLISHMENT

VOLUNTARY ESTABLISHMENT

Although groundbreaking from inception, Washington's Paternity Affidavit program consists of a relatively simple set of procedures. Affidavits originate from a variety of locations, but the vast majority (70%) arrive from hospitals where unmarried women delivered their child. DCS asks hospitals to provide unmarried parents with the Paternity Affidavit form, a booklet that describes paternity establishment, and provide access to a video or toll free phone number to augment the information in the booklet. Federal and State law requires hospitals to provide both written and oral paternity information.

Many couples have the affidavit notarized at the hospital. Others complete the form after discharge, later returning it to the hospital, local DCS or Community

Service Office (CSO), or sending it directly to DOH. Parents have ten days from the birth of their child to return the form to the hospital and avoid the \$15 filing fee, providing the hospital has not submitted the birth record to DOH. Parents who return affidavits to DCS or a CSO at a later date can also avoid the fee; some hospitals will forward late affidavits to DCS for the parents. Hospitals receive a \$20 reimbursement for every completed affidavit.

Although rare, fathers may rescind the signed affidavit within 60 days for any reason, and may challenge the acknowledgement in court for up to two years on the basis of fraud, duress, or material mistake of fact.

Despite the conceptual simplicity and overall success of the program, widely varying hospital-specific success rates suggests practical complexities in program implementation. Interviews with hospital staff involved in the Paternity Affidavit program bear this out. Interviewees included nurses, nurse assistants, social workers, medical clerks, and technicians. Hospital staff described many different processes, as well as barriers to improving paternity establishment rates.

In addition, patients interact with the program in a variety of ways. Some hospitals reported that most affidavits come from parents completing them at the hospital, while others receive a significant proportion of their total after discharge. Absent fathers limit paternity establishment at nearly every hospital, although the reason for absence varies systematically with the patient population, and likely affects when hospitals receive completed affidavits

Regardless of procedural variations, interviewees consistently identified several program characteristics that drive paternity establishment rates. Staff in one hospital indicated they faced no significant barriers, stating, “It is part of the hospital culture.” Staff from most hospitals, however, also identified a number of key issues, several of which mirrored barriers identified by DCS employees:

- **Shortened hospital stays challenge voluntary establishments.** Most hospital staff agreed the duration of birth-related hospital stays have shortened over time, with some patients discharged in as little as 24 hours. Brief stays and competing demands for the parents’ time (e.g., family visits and health consultations) leave less time for hospital staff to introduce and thoroughly discuss the paternity issue.
- **Fathers absent from the hospital at the time of birth create a limit to the program’s reach.** Hospital staff cited the absence of the biological father at the hospital as the main barrier to securing a signed affidavit. Fathers who are incarcerated, non-citizens, migrant laborers, or young are among those least likely to be present at the hospital at the time of child’s birth. Fathers may also be absent if they are on active duty military.
- **Characteristics of the patient population drive hospitals’ paternity establishment rates.** Patients from particular demographic groups respond to the program in different ways. Interviews with hospital

staff suggest that concentrations of patients from a single ethnic or socio-economic background can skew program results.

Interviewees also identified a common set of program characteristics that drive outcomes:

- **Successful programs present paternity information early and often.** Some hospitals make a concerted effort to begin presenting paternity information prior to delivery. Some hospitals reported securing signed affidavits through follow-up contact with a child's parents after discharging the mother.
- **Employing social workers or other non-medical staff as the main point of contact for paternity issues can reduce the burden on nurses and other medical staff.** Paternity establishment fits naturally into a social worker's mission, and medical records staff often have better tools to identify unmarried parents than do nurses. Although medical staff at most hospitals demonstrate strong support for the program, many nurses feel constrained by the need to address a long list of issues, including paternity acknowledgement, before discharge.
- **Staff and administrative support for the program improves paternity establishment rates.** Direct contact with DCS helps to maintain staff and administrative support for the Paternity Affidavit program. Staff indicated that training sessions increased their knowledge about program specifics and their enthusiasm for the program's goals. Without this contact, interest in the program can dissipate.

Clear guidance on program policies can improve consistency. Some hospitals offered the Paternity Affidavit video to nearly all eligible parents, while others relied almost exclusively on the DCS phone line to provide the required information. The significant variation both across and within hospitals in the types of identification notaries would approve creates confusion and may limit the program's operation

Presentation of paternity materials

Providing appropriate information about paternity establishment requires, at a minimum, identifying unmarried mothers. In most cases, hospitals rely on either verbal or written confirmation of marital status collected at admittance, on the birth certificate, or in the discharge paperwork. One hospital reported identifying single mothers by the absence of a father on the complimentary birth certificate offered by the hospital. One hospital reported presenting paternity information only when parents asked, while others actively attempt to persuade parents to learn about and sign an affidavit whenever the hospital cannot identify the legal father for a newborn.

Staff in each hospital described a different process for raising the issue of voluntary paternity acknowledgement with patients. Additionally, a variety of staff involved, including nurses, nurse assistants, social workers, medical clerks, and technicians may present the relevant information. This is not surprising given that hospitals

Staff indicated that it is helpful to address the affidavit and the birth certificate at the same time. Fathers often want their name on the child's birth certificate, and hospital staff use this as an opportunity to inform them that their name cannot appear on the birth certificate unless parentage is established. Many interviewees pointed to fathers' desire to be named on the birth certificate as the key factor in acknowledging paternity.

have the flexibility to develop processes that work in their unique environments. There were a few common parameters, however. First, as described above, hospitals must submit affidavits to the Department of Health within ten days of the birth. Second, the State develops the materials that staff use to educate patients about paternity. These include a booklet and a video. Hospital staff did not provide examples of in-house materials.

Generally, in-hospital paternity establishment is discussed near the end of a mother's hospital stay. A number of hospitals described a process similar to the following:

- The nurse knows the patient's marital status from the patient's face sheet (filled out when the patient enters the hospital). Depending on the hospital, the nurse might provide a booklet that describes the Paternity Affidavit process, offer to show a video, or both. Some provide the DCS toll-free number. Patients often do not receive both written and oral explanations of the process. This process can take up to 30 minutes.
- Parents generally fill out the affidavit shortly before they leave the hospital. Discussing the affidavit with unmarried parents is part of the normal discharge checklist. Often, hospital staff present the affidavit at the same time as the birth certificate forms.
- If the patient expresses interest, a notary is called in to review the form and witness the signatures.
- The Paternity Affidavit is attached to the birth certificate worksheet and filed with the Department of Health. If a father expresses an interest in signing an affidavit but is not available before the mother is discharged, hospital staff indicated that he can return and have the paperwork notarized, so long as it is within the 10 day window.
 - In some instances, the patient, the putative father, or both ask for a genetic test. Hospital staff indicated that they do not provide genetic testing on site. If patients request information, staff will generally advise them to look in the yellow pages. A number of hospitals also maintain a list of private testing firms in the area that they can give to

patients. However, due to the cost (about \$600) parents often are not responsive to this option.

Hospitals often include information about paternity establishment in the discharge packet, which may include discharge instructions, baby care information, infant photograph order forms, consent for immunizations, and any of a number of other items. Staff from several hospitals reported that nurses and mothers alike find the amount of discharge material overwhelming at times. They expressed concern that mothers have limited attention to devote to paternity and other important issues in the hours immediately following delivery.

According to one interviewee, “most want to open their presents... many just want to get home.” Interviewees at one hospital were not sure how the hospital dispensed paternity information even though the hospital’s paternity establishment rate was above average.

Paternity information often gets lost in the vast amount of material nurses present to mothers prior to discharge, frustrating staff and parents alike. Some hospitals present paternity information well before discharge to allow parents more time to digest the material.

Some hospitals described significant variations to this process. One hospital, for example, begins the paternity discussion during pre-natal sessions (Stork Express). The sessions allow women to review and process forms, tour the birthing unit, and complete other important tasks prior to delivery. Parents receive a booklet about the Paternity Affidavit process and forms, when appropriate, and are told which parts of the form they can fill out before birth. Representatives from nearly all hospitals agreed that presenting the material earlier could improve hospitals’ paternity establishment rates. Staff generally thought that additional outreach after discharge was beneficial as well.

A few hospitals present paternity information well before discharge, sometimes as a standalone presentation. One hospital offers the information as part of the standard discharge packet, but on the day or evening after birth, during the typical 2-3 day hospital stay (longer than the average length of stay reported by most other hospitals). This allows parents more time to digest the material before leaving than they have at many hospitals.

Although most hospitals have the Paternity Affidavit video, there were mixed reports about the extent to which hospitals showed it to parents. The fraction of parents who reportedly watch the video when offered also varies significantly, from “60-70 percent” to “almost never.” One interviewee stated that she finds parents who want to see the video “maybe once in five years.” She did not identify the proportion actually viewing the video.

A few hospitals do not show the video, but instead referred parents to a toll free number with recorded information. Another hospital gave parents a letter from DCS regarding the Paternity Affidavit that appeared to be somewhat

outdated and contained incorrect information. Yet another hospital had an older version of the video (1997) and declined to show it.

In some cases, equipment availability drives the presentation of the video. Larger hospitals were more likely to have permanent, in-room, viewing equipment (TV with a VCR or DVD player), while many hospitals rely on mobile units to present educational videos. One smaller hospital had to continually request new paternity VHS tapes because the VCR regularly ruined the videos. In other cases, hospitals relied on the hotline for expediency or because they didn't know about the video.

Non-medical staff often play an important role in presenting paternity information. At some hospitals, medical records staff identify unmarried mothers and distribute the affidavit. Social workers play the primary role in discussing paternity at other hospitals. Social workers can play a larger role in paternity establishment at larger hospitals, primarily because they are more likely to have available social work staff.

Social workers generate about 60 percent of the Paternity Affidavits recorded at Southwest Washington Medical Center, one of the largest birthing hospitals in the state, while nurses generate the remainder. On the other hand, social workers played a much smaller role at Tacoma General Hospital, another large birthing hospital. An employee from a smaller hospital reported that social workers at her hospital were helpful, but not central to the program's operation. An interviewee from another hospital stated that social workers at her hospital "only get the complicated cases."

Although hospital staff generally reported that the program operated smoothly, all thought that increased paternity-related staff would result in better program outcomes. One interviewee stated the biggest deterrent to obtaining completed affidavits at her hospital is the low staff to patient ratio, and numerous respondents felt their program would operate more effectively with additional staff. The desired staff additions ranged from increasing the unit secretary coverage to hiring a social worker dedicated largely to the Paternity Affidavit program. Employees at nearly all hospitals felt that insufficient notary availability restricted the number of affidavits received.

In many hospitals, staff felt that relying on non-medical staff would best serve the program, and having staff, most likely social workers, dedicated to the program would be ideal.

- Although generally supportive of the program's goals, some medical staff view paternity establishment as a burden on their already busy schedules and outside of their core mission to serve patients' healthcare needs.
- One secretary voiced the common belief that the program works better when pursued by whoever types up the birth records and certificates.

Medical records staff may have a better chance of identifying candidates for signing a Paternity Affidavit.

- Some medical records employees stated that the paternity program could be a significant burden given their other workload. They suggested that paternity establishment fits more naturally with social workers' central duties.

The emphasis hospital administrators place on paternity establishment also affects the program's success. One interviewee noted that paternity establishment was harder to pursue without staff time dedicated exclusively to the Paternity Affidavit program. She noted that, with dedicated resources, changing hospital priorities won't inadvertently reduce the emphasis on paternity. She suggested that hospitals should dedicate one or more employees to informing all new mothers about paternity possibilities. Smaller hospitals may lack the resources to dedicate that much staff time to the program, however

Role of notaries

The Paternity Affidavit requires notarized signatures from the parents. In many cases, the employee presenting paternity information can notarize parents' signatures. Otherwise, staff will locate a notary for parents who express interest in signing an affidavit. The notarization process can take 10 to 30 minutes, depending on the number of questions raised by parents.

Most often, non-medical staff serve as notaries. Less common, medical staff perform this role. At a few hospitals, both types of staff notarized Paternity Affidavits. Nurses, obstetrical technicians, birth center administrative staff, and staff from medical records served as notaries at one or more of the hospitals visited.

Most hospitals indicated that notary coverage was generally available Monday through Friday during regular business hours. Coverage was thinner—or non-existent—during evenings and weekends.

Some hospitals reported a shortage of bilingual notaries.

Notaries at one hospital stated that the risk management unit had, in the past, been reluctant to allow staff to notarize affidavits during their shifts, although the unit has no such concerns at present.

Notaries varied, even within a single hospital, in the types of identification they accepted, although they typically ask the father for government-issued photo identification (e.g., a driver's license from Washington or another state, a military identification, a state-issued identification, a passport). There was

some dispute as to whether a school photo identification was acceptable (staff in one hospital said they received guidance that it was, while those in another indicated it was not valid identification), or whether foreign-born parents could use an international identification card. In one instance, a notary accepted a mother's word and a high school yearbook photo as sufficient proof of identity.

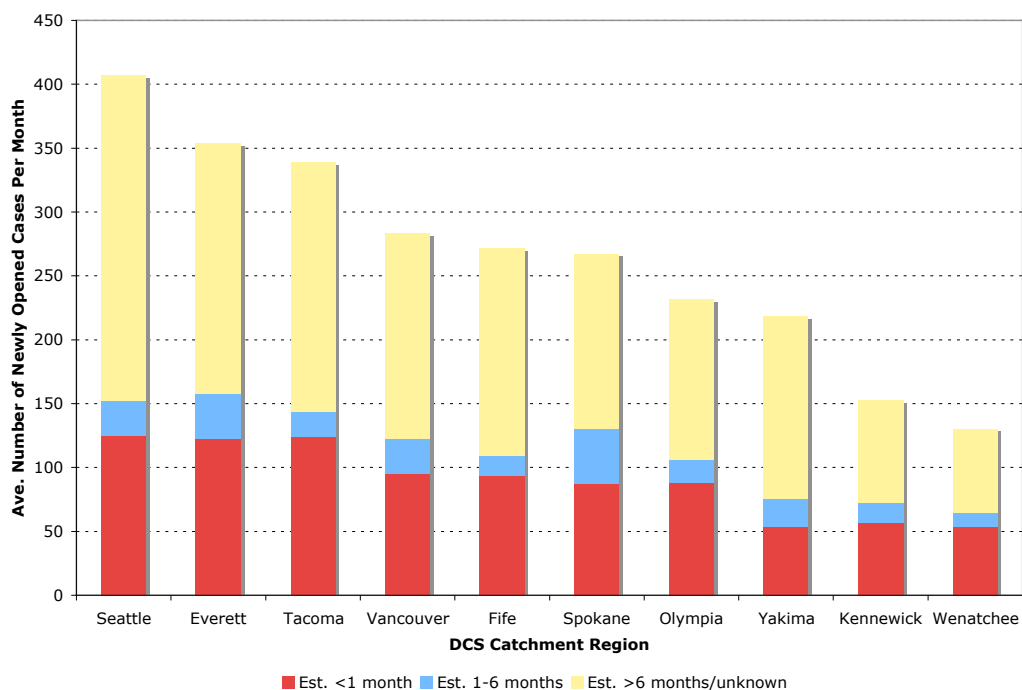
Although most notaries felt they had a solid understanding of the program requirements, a few raised questions or concerns about the Paternity Affidavit program. For example, some were unsure whether their notary stamp applied to the validity of an entire document or just an individual's signature

Despite the inherent uncertainties in establishing an individual's identity, some notaries tend toward permissiveness, but not a single interviewee felt that their hospital was too lenient in notarizing Paternity Affidavits. Several individuals indicated concern that hospital notaries have refused to notarize many potentially valid affidavits. The concern arises from a belief that securing an affidavit as early as possible provides the greatest probability of success because the population of unmarried mothers is not likely to pursue the paternity issue unless and until the child enters the child support system.

DCS field offices

As noted earlier, the State must establish paternity prior to filing a child support order. At any one time, DCS regions vary significantly in the number of open cases requiring paternity establishment. Figure 2-6 presents the average number of child support cases for children of unmarried mothers opened per month in each DCS regions between January 2004 and April 2006.

Figure 2-6: Average monthly number of cases opened by DCS region January 2004-April 2006 and time until establishment.

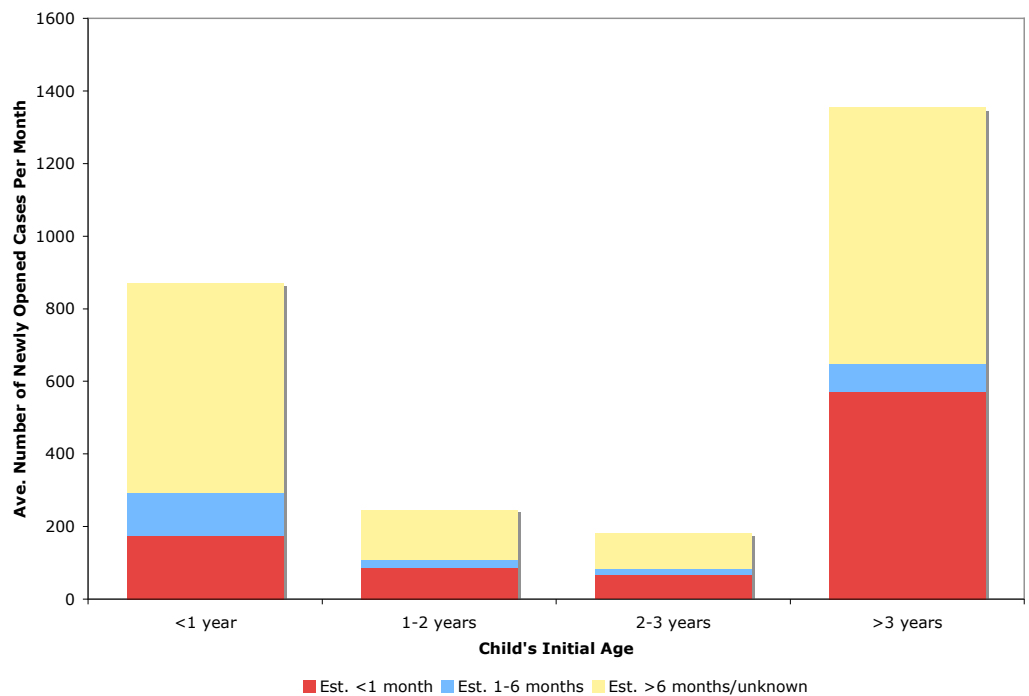


Source: DCS case records 01/04-04/06.

The figure also illustrates the typical time until DCS establishes paternity.⁴ In every region, paternity was established (administratively or through the courts) within six months for between 39 and 50 percent of all newly opened cases. Voluntary establishments occur more quickly, on average, than court-ordered establishments and accounted for between 44 and 58 percent of all establishments in each region during this period of time.

Case outcomes vary by age of child as well. Figure 2-7 illustrates the distribution of age the month a case opens during the same time period.⁵

Figure 2-7: Average monthly number of paternity cases opened by age of child January 2004-April 2006 and time until paternity establishment



Source: DCS case records 01/04-04/06.

Paternity establishment for children less than one year old occurs within one month for only 20 percent of cases, but 42 percent of the time for cases involving children greater than three years of age. More significantly, voluntary acknowledgement accounts for 60 percent of all establishments for child under one year and for 58 percent of all establishments for children under three years, but only for 42 percent of all establishments for older children. This reinforces the importance of strong hospital-based Paternity Affidavit programs.

⁴ Cases for children with previously established paternity are counted as established in less than one month. Cases where paternity has not been established as of April 2006 are counted as taking six months or longer. For many of these cases, DCS may no longer have reason to establish paternity (e.g., a child is no longer a minor or DCS loses jurisdiction over a case).

⁵ The chart omits a small number of cases (less than 0.2 percent) for which age could not be determined.

DCS field offices are responsible for monitoring the Paternity Affidavit process in the hospitals in their catchment area. Each field office has two staff designated as Paternity Affidavit Coordinators; they are assigned to work two full days per year per hospital. Although the coordinators were enthusiastic about the program, they noted that time constraints limit their ability to stay in regular contact with the hospitals. Staff from one field office indicated that it is difficult to balance their role as Paternity Affidavit Coordinators with their primary responsibilities. Although they try to call the hospitals in their area regularly, the visits as part of Bright Start were the first since 2002.

DCS employees indicated that hospital staff and administrators are generally receptive to the Paternity Affidavit program, although in a few exceptions hospitals were slow to embrace the program. In these cases, hospitals are slow to restock supplies and do not always have Paternity Affidavits or the corresponding brochures on site. They are also less likely to show the video.

During initial hospital training sessions, DCS emphasized that parents who have signed the Paternity Affidavit after the ten-day deadline can send or drop off the document at any DCS field office to avoid the filing fee. Some Paternity Affidavit Coordinators indicated that they provide pre-paid envelopes with the DCS address to the hospitals that staff can give parents to make this process even easier.

Despite initial opposition to the Paternity Affidavit program, DCS staff feel that some local prosecutors have become more receptive. Field office staff noted that prosecutors in Pierce County will sometimes offer the option of the Paternity Affidavit to parents as an alternative to the formal court process. This is often parents who have not previously heard of voluntary paternity acknowledgement, and, after being told about it by the prosecutor, choose to sign the form as opposed to going through the legal process. Field staff estimated that maybe 10 percent of cases going to the prosecutor end up with signed affidavits.

Other community partners

DCS and other regional partners (e.g., neo-natal clinics, WIC centers) provide additional opportunities for a father to formally and voluntarily establish his parental rights and responsibilities. The success of these second efforts depends largely on the effort of the DCS field offices and breadth of their networks with partnering agencies that are likely to come into contact with the parents after they leave the hospital.

DCS maintains an extensive database of contacts for partners in the broader community. These organizations include a wide variety of entities, including legal clinics, Head Start, prenatal and postnatal clinics, tribal organizations, and many others. However, these partner organizations play a relatively small direct role in increasing the rate of voluntary paternity establishments. Many organizations likely play a larger role in the program than indicated by the number of affidavits generated, but the number of forms ordered provides an approximate upper bound

on each organization's contribution to the State's overall paternity establishment rate. Table 2-2 presents an approximate count of the total number of affidavits ordered by each type of community partner between January 1997 and March 2006.

Table 2-2: Average monthly number of paternity establishment cases opened by age of child January 2004-April 2006 and time until establishment

Type of Organization	Total Affidavits Ordered		Number of Orgs.
	01/97-03/06	Percent of total	
Other/unknown	2340	35	28
Pre- or post-natal clinic	1560	23	33
Tribal organizations	1291	19	28
Child advocates	1289	19	41
Headstart/ECEAP	140	2	61
WIC	125	2	104
Grand Total	6745	100	295

Source: DCS administrative records

The table excludes affidavits sent to hospitals, child support offices, prosecutors, and midwives.⁶

- **Organizations in the largest category, “Other/unknown” ordered over one third of the affidavits sent to these types of community partners.** Representative “Other” organizations include Highline School District, a private practice doctor, Grant County Youth Services, and a community health clinics.
- **Child advocates received a significant number of affidavits.** This category includes private attorneys, legal services offices, Planned Parenthood, and others.
- **The total number of affidavits ordered by these organizations was a small proportion of the total number of affidavits received by the State over a similar time period.** Total requests from these groups average less than 750 per year; many organizations ordered only a single batch of forms during the nine-year period, suggesting that many of the forms remain unused. In contrast, the State has received well over 100,000 signed affidavits over the last 9 years.

These statistics do not indicate either that the partner organizations are unimportant or that they could not generate a significant number of completed affidavits. Whether extending Bright Start to these community partners can amplify their supporting roles in paternity establishment remains to be seen.

⁶ Entries in the table may over- or underestimate the true number of forms ordered, and do not necessarily indicate the number of forms given to, or completed by, clients. Many organizations in the database did not order affidavits, including child support offices from several other states. Some organizations fit into multiple categories but were only counted once.

BARRIERS TO VOLUNTARY PATERNITY ESTABLISHMENT

Staff training and administrative support

When the Paternity Affidavit program was implemented, DCS provided onsite training for interested hospitals and held regular conferences to address questions and concerns about paternity establishment. The meetings also served to train new staff in the goals and procedures of the program. As noted above, contact between some DCS field offices and hospitals has been less frequent in recent years. Hospital staff identified remaining questions about the Paternity Affidavit program and that more frequent meetings with DCS field office representatives may be warranted. For example, staff in one hospital were unaware that they could order additional Paternity Affidavit forms, brochures, and videos. Some hospitals were not aware of the range of available materials or that they could receive updated products.

Diminished contact with DCS over recent years likely limited paternity establishment rates at some hospitals. Some hospital staff were unaware of the existence of a Paternity Affidavit video. Staff from one hospital did not know who distributed paternity information or how affidavits were completed.

Additional DCS contact would prove beneficial for hospitals with high staff turnover and, hence, less program continuity. Additional contact would likely also have garnered stronger support from hospitals that were reluctant or unwilling to provide adequate resources for the Paternity Affidavit program. Employees from every hospital expressed interest in improving their processes; staff from several hospitals asked what the successful hospitals were doing differently. Staff in each hospital appeared to appreciate the “refresher course” on Paternity Affidavits conducted as part of the Bright Start demonstration project implementation. Several hospitals requested that Bright Start manager John Hoover or other DCS staff return to provide additional training.

Along with a hospital’s overall orientation towards the paternity program, hospitals vary in the degree to which they follow up with unmarried parents. As one interviewee suggested, “someone needs to dog it every day.” Intensive pursuit is particularly important for parents with limited motivation or ability to establish paternity independently. Hospitals reported using a variety of approaches to secure notarized affidavits both before and after a mother is discharged:

- Most hospitals offer a complimentary birth certificate. Although not a legal document, fathers often want to be identified on this certificate. Most hospitals refuse to add a father’s name to the certificate or issue the father a hospital wristband until the father establishes paternity.
- Some medical records staff call parents after discharge if they have not returned a notarized affidavit.

- Hospitals lacking full-time notary coverage often bring in outside notaries to increase coverage.
- Many hospitals will wait to submit a birth record to DOH if the parents express a desire to return an affidavit. For example, one hospital noted that if a father expresses an interest in signing an affidavit but is not available before the mother is discharged, he can return before the 10-day submission period and have the paperwork notarized. One notary stated that she flags these cases with a post-it note so that medical records staff know not to file the certificate immediately.

Patient characteristics

Patient demographics can affect the operation of a hospital's Paternity Affidavit program. For example, hospitals in the largely rural and heavily agricultural Yakima region serve populations that include a large proportion of migrant, immigrant, and undocumented residents. These populations present challenges to the Paternity Affidavit program for a variety of reasons.

For one, parents are, understandably, reluctant to sign official documents they do not understand. Although DCS provides Paternity Affidavit information in Spanish and many hospitals have on-site translators, resources often are inadequate. Interviewees at Toppenish Community Hospital, for example, reported that about 70 percent of mothers speak Spanish, while only 10 percent of staff are bilingual. These staff, furthermore, may not be otherwise involved in the Paternity Affidavit program, and thus, not in a good position to describe it to patients. St. John Medical Center avoids this issue by using a telephone system that provides immediate essentially instantaneous translation capabilities.

Staff from other hospitals noted that Russian, Korean and Vietnamese language materials would be helpful. DCS does not provide Paternity Affidavit information in these languages at this time. The deaf population is relatively small, and, anecdotally, hospitals see few babies born to deaf parents. However, one interviewee suggested close-captioning the video.

Even with sufficient hospital-based translators, barriers to paternity establishment remain.

- Staff from hospitals serving significant Hispanic populations reported that many Hispanic fathers worried that signing the Paternity Affidavit would weaken their rights.
- In many cases, a man's immigration status may weigh heavily on his willingness to sign a Paternity Affidavit. Marriage can restart the immigration process, and patients may not understand the legal difference between paternity and marriage. Staff do not necessarily know what, if any, relationship the DCS Paternity Affidavit program has with immigration agencies or deportation procedures

Besides communication barriers, hospital staff reported that many parents are young and lack the maturity or desire to address paternity issues. According to staff:

- Teenage mothers often have no desire to contact the biological father or have parents who have “driven off” the baby’s father.
- Sometimes the parents of the putative father will insist on a genetic test before their son commits to legal fatherhood. This is especially in common with births to younger parents.
- In cases involving teenage mothers, the putative father is sometimes much older and reluctant to sign the affidavit (or even come to the hospital) for fear of being prosecuted for statutory rape.
- Some first time mothers worry that the Paternity Affidavit gives the father legal rights to his child that he would not otherwise have.
- Some parents will not sign or discuss the affidavit because they think that “everything will work out,” and they do not see the need to involve the state in what they deem to be a personal matter.

Some mothers have legitimate reasons for avoiding contact with their child’s father; some have a restraining order enforcing separation. On the other hand, some mothers are married to, and have children with, another man. When they subsequently have a baby with someone other than their husband, they cannot afford to, or do not want to, get divorced. Sometimes a mother cannot locate her husband and the father of her child cannot legally acknowledge paternity until the husband signs a denial of paternity. These cases will not lower the overall paternity establishment rate, but do restrict accurate paternity determinations

Hospital staff also noted other barriers, including:

- Parents don’t understand the legal implications of paternity establishment. Despite the fact that state law mandates simple language for program materials, many parents find the paternity establishment process confusing and the legality of the affidavit frightening.
- Poverty can negatively affect paternity establishment, particularly when it requires additional travel or payment of fees. One medical records clerk described many parents as unlikely to travel to obtain a birth certificate for their child’s school enrollment, let alone for something as seemingly abstract as paternity.
- Some fathers do not sign simply because they want to avoid even the possibility of having to pay child support.

Absentee and unknown fathers

Mothers may identify multiple potential fathers for their baby; potential fathers, in turn, may lack certainty about their fatherhood. In some instances, the patient, the putative father, or both ask for a genetic test. None of the hospitals visited provide onsite genetic testing.

If patients request testing information, staff generally advise them about testing possibilities. A number of hospitals maintain a list of private testing firms that they give to patients. However, parents may not follow through on with a genetic paternity test due to the cost (about \$600). Barring genetic confirmation of paternity, some potential fathers will not sign a Paternity Affidavit. Absentee fathers also present a barrier to paternity establishment.

Outside of the military hospitals (discussed further below), interviewees cited incarceration as the most common reason for a father's absence. Incarceration creates additional barriers for fathers who would otherwise acknowledge paternity. Staff from several hospitals reported difficulties securing permission for an inmate to sign the Paternity Affidavit in the presence of the prison's notary. One trainee at St. John Medical Center reported having had difficulty in getting a signature from a school-age inmate who was out of prison during weekdays to attend school. The correctional authorities would not allow the student to deviate from his daily travel to and from the prison. Official paternity establishment can also be difficult for children of immigrant mothers whose father lives in another state or country and lacks the ability to travel on short notice.

Paternity establishment as informal adoption

Some critics of the Paternity Affidavit process suspect that a subset of parents treat the Paternity Affidavit as an informal route to adoption (i.e., the signatory knows he is not the biological father of the child). In this way, the couple avoids the significant procedural and financial barriers to legitimate adoption. Although this is not a barrier to signing an affidavit, in the same was as communication problems or other issues, some feel this is an inappropriate use of the Paternity Affidavit. Several interviewees echoed this belief, although not necessarily the concern. Some felt that it was none of their business whether parents wanted to perjure themselves with the affidavit, and that having a man voluntarily establish paternity could benefit the family regardless of the true biological father's identity. In contrast, one interviewee stated that, "We don't want people to sign if it's not appropriate. It's a nightmare later on."

The site visits yielded few reports of these informal adoptions, although some notaries reported having felt that they had, at times, been asked to notarize forms they believed to contain false information. Other staff felt that mothers sometimes convince a man to sign the Paternity Affidavit to ensure that her child's legal father is the most promising of the "eligibles."

Military birthing facilities

Military birthing facilities such as Madigan Army Medical Center operate in a unique environment along a variety of dimensions. The patient population served at these facilities differs significantly from any civilian hospital's patient population. Residents at Fort Lewis come from all areas of the country; soldiers' spouses may come from numerous other countries. In almost all cases, treatment at a military hospital requires that a patient be either in the military or the dependent of military personnel. As such, there are generally two circumstances under which a military hospital birth would necessitate a Paternity Affidavit:

- **Active duty personnel.** If the mother is unmarried, the Paternity Affidavit is introduced in much the same way as in other hospitals. However, the process is more complicated if the mother is married and the father is not her husband.
- **Daughter of active duty personnel.** If one or both of the parents of the new mom are in the military and she is still a dependent, she can give birth at a military hospital. Less common, these cases typically involve teenage mothers. As with other hospitals, staff in the military hospitals indicated that these cases pose particular problems with relation to the Paternity Affidavit process.

Many military fathers miss the births of their children for reasons not applicable to civilian populations. Deployment can result in a significant number of absences; long deployments coupled with uncertainties about paternity magnify any reluctance to establish paternity. In addition, deployment significantly complicates the logistics of obtaining a notarized affidavit with both parents' signatures. Health Insurance Portability and Accountability Act (HIPAA) requirements can also present difficulties for deployed dads who may have trouble obtaining even basic birth statistics while deployed.

In contrast to the unique difficulties in establishing paternity, however, military hospitals have an additional incentive to establish paternity, as the military may not have to pay birth expenses under certain circumstances. If the father is a civilian, for example, the military may cover birth expenses, but if the mother is eligible by being the dependent of military personnel, the baby is not eligible for care unless the father is in the military. If not, the army actively attempts to determine the party responsible for treating the baby.

That adultery is a criminal offense under the uniform code of military justice (UCMJ) creates another barrier to paternity establishment unique to the military. This may deter otherwise willing parents from officially acknowledging paternity for fear of the sanctions available under the UCMJ, including possible time in prison. Judge Advocate General (JAG) staff at Madigan noted that the military could view a formal paternity acknowledgement as proof of adultery if either parent were married to somebody else.

Other limits to paternity establishment

Certain situations do not lend themselves to paternity establishment, regardless of the parents' willingness. Although examples cited by interviewees likely have only a minor impact on paternity establishment overall, they nonetheless limit the potential success rate. Examples include:

- **Non-traditional family arrangements.** One interviewee noted that gay and lesbian couples present a unique challenge for paternity establishment. Children born to women with female partners, for example, will probably not establish paternity in most cases. As a result, these children lower the overall paternity establishment rate. The effect is, however, likely small.
- **The transfer of a newborn for medical reasons.** Doctors may transfer a baby, often premature, to a different hospital for medical reasons. In most such cases, paternity establishment will have a low priority given that the transfers generally involve medical emergencies.

COURT-BASED ESTABLISHMENT

Voluntary paternity acknowledgement provides a quicker and often less adversarial path than does establishment through the court system. However, close to half of all paternities established by DCS proceed through the court system. DCS estimates that establishing paternity through the courts costs an average of \$1,600 per case, compared to less than \$150 for a voluntary acknowledgement of paternity. Much of the added expense occurs because judicial establishments can take significantly longer than voluntary acknowledgements of paternity.

Private parties may seek to establish paternity through the courts, but DCS initiates the majority of paternity establishment cases. Paternity proceedings begin when DCS receives notice that a mother is either seeking public assistance or seeking to establish a child support order. A father will have already acknowledged paternity in many instances, allowing an administrative determination that does not require the full legal establishment process. DCS first examines a child's birth certificate, if available, and searches for an existing Paternity Affidavit.

Local DCS staff will refer the case to a prosecuting attorney if paternity has not been established previously. The prosecutor will create a case file, request an interview with the child's mother, and will seek to identify the most likely father(s). The prosecutor will then send a summons notifying the likely father of the order to establish paternity and his obligation to submit to a genetic test.

The man may, at this point, be offered the opportunity to sign a Paternity Affidavit. If he does not sign an affidavit, genetic test results will determine the next step. If test results are negative, the prosecutor will summon additional men

until exhausting the list of candidates. After establishing paternity, the court-ordered paternity process also establishes custody and visitation schedules.

Involvement of DCS field officers in paternity cases varies by region. In most areas, the prosecuting attorney shoulders most of the burden for establishing paternity once DCS makes a referral. In the Olympia and Vancouver regions, however, DCS staff perform more of the work. Caseworkers may attempt to contact potential fathers to divert the process onto the administrative establishment track by securing a voluntary paternity acknowledgement.

A well functioning Paternity Affidavit program shortens the paternity establishment process for children who enter the child support system later in life by establishing paternity earlier in life. The program can also increase the proportion of paternity cases resolved administratively by obtaining affidavits from fathers who might otherwise resist paternity establishment later, freeing prosecutorial resources to pursue more difficult cases.

Bright Start Implementation and Perceptions

OVERVIEW OF BRIGHT START

In mid-2005, the federal Office of Child Support Enforcement (OCSE) awarded Washington State a demonstration grant to implement and rigorously evaluate enhancements to its pioneering work in voluntary paternity establishment. Specifically, the demonstration, called the Bright Start Program, seeks to mitigate the existing barriers to voluntary establishment by:

- 1) strengthening the delivery of the existing Paternity Affidavit program and
- 2) expanding the services associated with the program to include no-cost genetic testing, marriage education, and dispute resolution mediation services.

We describe the details of these overarching, complementary Bright Start strategies below.

Strategy 1: Strengthen delivery of the existing features of the voluntary paternity establishment program. The rate of voluntary paternity acknowledgement varies across DCS regions. Bright Start seeks to improve the rates by implementing the following strategies in four demonstration regions:

- **Recruit and train additional hospital-based notaries.** Anecdotal evidence suggests that the inconsistent availability of notaries in hospitals, who are required to verify the identity of affidavit signers, may contribute to lower rates of voluntary paternity acknowledgement in hospitals. Bright Start will work with hospitals selected for the demonstration to increase notary coverage. The goal is for multiple notaries to be available in each hospital to certify affidavits during peak workday hours.
- **Targeted recruitment of hospital-based social workers.** Given the time constraints of many nurses and other medical staff, Bright Start hopes to strengthen the existing system by recruiting social workers to present Paternity Affidavit information. As part of the demonstration, DCS staff will identify and recruit non-medical, social work professionals to serve as the key hospital-based coordinators of the affidavit program.
- **Update DCS's paternity establishment video and information booklet to reflect new services.** DCS currently encourages all hospitals to allow parents to view a brief video that explains the

benefits and responsibilities inherent in signing a Paternity Affidavit. For the demonstration hospitals, Bright Start will add an additional segment to the video highlighting certain services available through the grant. In addition to the video, Bright Start has developed an easy to read information booklet.

- **Expand partnerships with non-hospital, community partners.** Bright Start will actively seek participation from entities that have contact with unmarried parents (both pre- and post-natal). These potential partners may include, but are not limited to local community services offices (public assistance), Head Start programs, WIC programs, pre- and post-natal health clinics, and prosecuting attorneys.

Strategy 2: Expand the range of services associated with the Paternity Affidavit program. In addition to improving delivery of the existing program, Bright Start expands the range of services associated with voluntary paternity process. Specifically, the program:

- **Offers no-cost genetic testing for parents who do not sign the Paternity Affidavit at the hospital.** For some parents, the key barrier to signing the affidavit is the lack of certainty around paternity. As part of the demonstration, Bright Start offers buccal swab genetic testing through contracted genetic testing facilities located in areas served by the demonstration. Bright Start pays for each test at the state rate of about \$126 (compared to the private sector rate of about \$600). Once the test has been conducted, staff at the genetic testing laboratories will provide parents an opportunity to sign a Paternity Affidavit.
- **Marriage education services.** Bright Start plans to inform unwed parents about no-cost marriage education services. The marriage education services will offer basic relationship skills through which couples can learn how to start and foster a successful marriage. The coursework will focus on the realistic emotional and financial expectations of a marriage, as well as how a healthy marriage can benefit children. Bright Start information booklets and videos will describe these services.
- **Parenting Plans.** For couples with no short-term interest in marriage, Bright Start offers parents an opportunity to meet with trained mediators at a local Dispute Resolution Center to develop a formal parenting plan. Washington's non-profit dispute resolution centers allow parents to determine the mediation process and the parents make all of the decisions about how they want to resolve their conflict. The confidential mediation sessions are free of charge.

DCS anticipates that the combination of new Bright Start services and the renewed attention to the existing program will result in measurable increases in the rate of voluntary paternity establishments among unmarried parents. With the increase in voluntary paternity acknowledgements will come a corresponding

decrease in the number (and share) of expensive court-ordered paternity establishments, which will free court docket time and save public resources.

DCS also anticipates that an early emphasis on non-adversarial methods of child support enforcement will foster a long-term cooperative relationship with both parents, which should expedite the timing of order establishments, improve payment rates for current support, and mitigate the accrual of arrears.

BRIGHT START IMPLEMENTATION

The Bright Start demonstration involves 17 hospitals in four of Washington's ten DCS catchment regions, including all but one of the birthing hospitals in those regions. The Bright Start hospitals comprise roughly a quarter of all birthing hospitals in Washington, and delivered 36 percent of all babies born to unmarried mothers in 2003, the most recent year for which DCS had complete data. The Bright Start hospitals submitted Paternity Affidavits for 40 percent of these births, somewhat less than the 48 percent achieved statewide, although the rates at individual hospitals ranged from 15 to 69 percent. The four Bright Start regions encompass a wide range of hospitals, from small, rural, birthing hospitals to large, urban medical centers and military hospitals. The range of observed program characteristics reflects the spectrum of hospital-based Paternity Affidavit programs across Washington.

Implementation of the Bright Start program occurred when staff received the training provided by Bright Start manager John Hoover. He trained staff at the first hospital on April 17th, reaching all Bright Start hospitals by May 10th, although some hospitals received additional follow-up training.

To begin each training, Mr. Hoover gave a brief overview of the Paternity Affidavit program, noting its benefits to parents and children as well as to Washington. He then showed the updated video, described each of the new services, and provided staff with project materials (i.e., new brochures, updated videos). He instructed hospitals to begin offering the Bright Start services as soon as the training ended.

Following the trainings, evaluators from ECONorthwest and Lewin met briefly with hospital staff to discuss the Paternity Affidavit process as it currently stands and their impressions of the new services being offered through Bright Start.

In addition to the hospital visits and interviews with DCS employees, we conducted interviews with community partners of the Paternity Affidavit program, including existing partners (e.g., prosecuting attorneys' offices), and new organizations that will offer Bright Start services (e.g., Dispute Resolution Centers, marriage education providers). The remainder of this chapter provides a detailed description of the changes to the Paternity Affidavit program implemented with Bright Start and of the reactions of staff from hospitals and other community partners.

Despite Bright Start's attempt to provide the enhanced services at no cost to program participants, some costs may still burden parents, and can vary considerably by county. For example, filing the parenting plan in court involves obtaining a copy of the signed Paternity Affidavit from DSHS (\$35), obtaining a packet of paperwork from the court (\$30), meeting with a court facilitator (up to \$20 in some jurisdictions), and the fee to file the plan (\$200 or more). Bright Start is exploring the feasibility of paying some or all of these costs when parents cannot obtain adequate fee waivers from the court.

UPDATED PATERNITY MATERIALS

The Bright Start program manager distributed the following Bright Start materials during the training sessions and provided contact information for ordering additional materials:

- **Updated Video.** The new Bright Start paternity video remains unchanged from the existing paternity video aside from an additional one-minute segment at the end describing two of the services available through the Bright Start: marriage education and parenting plans. The video does not refer to genetic testing. Bright Start omitted this service out of concern that putative fathers might request the free test, even when they might otherwise have signed an affidavit. Bright Start provides the video in both English and Spanish, in both DVD and VHS formats.
- **Bright Start Booklets.** Each hospital received booklets describing the processes for, and availability of, the genetic testing and parenting plan services. Each booklet includes a postage paid tear-off page that parents send to Bright Start. Both booklets are available in English and Spanish. As of June 2006, Bright Start had not developed a marriage education booklet, as the program has not identified service providers ready to serve Bright Start clients.

In a conscious effort to separate Bright Start from DCS, neither the video nor the booklets reference DCS. Instead, they describe the Bright Start grant from the federal Administration for Children and Families. The program was concerned that parents would be more reluctant to use the services if they were too closely associated with child support enforcement.

DISPUTE RESOLUTION CENTERS

Dispute Resolution Centers (DRCs) offer county residents mediation services for parties looking to voluntarily settle their disputes outside of the formal court process. DRCs handle an array of disputes including child custody/visitation, neighbor/neighbor, landlord/tenant, divorce, parent/youth, employer/employee, and citizen/agency. Mediation services are provided by professionally trained

volunteer mediators who help the participants reach informed, mutually acceptable settlements to resolve disputes.

Bright Start contracted with DRCs in three of the four target regions to provide the parenting plan mediation: Pierce County, Kitsap County and Yakima County. At this time, no DRC has been identified in the Vancouver region. Under the terms of the contract, Bright Start will pay DRCs a flat fee of \$400 per parenting plan.

ECONorthwest and Lewin staff met with DRC directors in three regions—Yakima (Yakima County), Silverdale (Kitsap County), and Tacoma (Pierce County). The evaluators asked the directors to describe the process for obtaining services, as well as their impressions of the Bright Start demonstration.

The process for obtaining services is similar at all sites. One party will call the DRC with an issue. DRC staff explain the protocol, and inform the caller that everything discussed is confidential (unless there are issues of child or elder abuse/neglect, which must be reported). The staff person conducting intake over the telephone engages in “active listening”—asking the caller to explain the situation and then repeating the key points so that the caller feels he or she has been heard. The intake worker then describes mediation and emphasizes that it is not legal advice and is not legally binding (as compared to arbitration). Finally, the intake worker collects information on the second party. Throughout this process, the staff person stresses that the DRC does not represent either party; rather, it provides impartial mediation services.

What is Mediation?

Mediation is a confidential, voluntary process in which impartial, professionally trained community members (mediators) help others in the community (the parties) reach an informed, mutually acceptable and durable settlement to resolve a problem(s) or dispute. Unlike an arbitrator who independently makes a legally binding decision for the parties, mediators assist the parties in reaching a settlement by helping them understand the issues and facts of the case and by providing a safe environment in which to negotiate. Once all positions are on the table, the mediators help the parties:

- Participate in a meaningful discussion of the issues
- Explore alternatives not previously considered
- Communicate the positions or proposals in understandable or more accepted terms
- Understand each other’s point of view concerning a particular issue without violating trust
- Identify what is important and what is negotiable
- Structure a settlement to resolve current problems and to meet future needs of both parties

Source: *The Mediation Process*. Dispute Resolution Center of Kitsap County

Parenting plans generally take between one and three sessions to complete. Each session lasts three or four hours. Once an agreement is reached, it is the responsibility of the parties to file the plan with the court. A judge decides if the plan is acceptable. According to DRC staff, judges usually respect the parents' agreement, unless it conflicts with the best interests of the child. Although DRC staff and volunteers discuss the filing process with the parties, they make it clear that their role is only to help in the preparation of the document.

The Kitsap County DRC has 50 mediators; the Pierce County DRC has 160, and the Yakima County DRC has 35. Each has considerable experience with parenting plans. DRC staff indicated that divorces and parenting plans are the most common disputes they address (the court in one county now requires parties seeking a divorce to attempt mediation before going to court). Bright Start clients will be unique in that they may be on amiable terms when they request a referral, in contrast to most DRC clients.

MARRIAGE EDUCATION PROVIDERS

The Bright Start proposal indicated that it would offer marriage education services through referrals to separate federally funded initiatives. The hope was to leverage existing marriage education services in two of the four target regions: Pierce County and Yakima County. Washington was one of 13 states to receive a Section 1115 waiver from the federal Administration for Children and Families (ACF) to operate a healthy marriage initiative using child support funds. ACF has funded two sites in Washington—Lakewood (Pierce County) and Yakima—to run from June 2005 to May 2010.

The mission of the ACF Healthy Marriage Initiative (HMI) is “To help couples who have chosen marriage for themselves gain greater access to marriage education services, on a voluntary basis, where they can acquire the skills and knowledge necessary to form and sustain a healthy marriage.”¹ Funded sites have flexibility in terms of the services they provide and how they are provided. The Lakewood and Yakima projects have experienced some delays and, as of June 2006, were not offering services.

Although initially optimistic that hospitals could offer marriage education along with the other Bright Start services, program staff reported disappointment at the slow development of the marriage education programs. A meeting in April 2006 with the Lakewood Healthy Marriage Coalition and a representative from ACF amply illustrated the pace of development. The coalition, consisting of social service organizations, churches, and other community institutions evidenced strong support for promoting marriage within Lakewood and the broader mission of the ACF marriage education program. They had not, however, committed to particular curricula for marriage education, let alone established who the classes would serve or where classes would occur. The Yakima project

¹ <http://www.acf.hhs.gov/healthymarriage/about/mission.html#background>

also faced numerous hurdles to establishing an education program, including significant changes in the project's partners.

As of the publication of this report (June 2006), the Lakewood site plans to offer Family Wellness, a 12-hour program (usually taught in six two-hour sessions) that focuses on concepts of commitment and cooperation. The Lakewood site is offering its first Family Wellness training course from July 19th to August 23rd. Other services, such as referrals to supportive services or employment services, are still being defined. The intended client base for the site encompasses individuals in the "Lakewood area." However, the site is still trying to define this population precisely and the extent to which it can serve non-Lakewood residents.

The Yakima site plans to begin offering services in February 2007. The site plans on offering services throughout Yakima County. The steering committee for the initiative is still in the process of identifying the most appropriate curriculum for the community and outlining a service delivery model.

GENETIC TESTING

The Bright Start program contracted with LabCorp to perform genetic paternity tests. LabCorp, based in North Carolina, has testing sites throughout the country. The lab contracts with Washington prosecutors and the Child Support Office to conduct their quick and non-invasive buccal swab genetic tests (taking a saliva sample from the inside of the mouth). Bright Start will pay LabCorp the state rate of \$126 per test, much less than the private rate of about \$600.

As part of Bright Start, hospital staff can offer individuals who are reluctant to sign a Paternity Affidavit the opportunity to receive a free genetic test. Unmarried parents request referrals through a tear-off form on the Bright Start Genetic Test handout. The form includes boxes for parents to indicate their availability for testing. Once Bright Start staff receive a referral request from unmarried parents, they will fax the request to LabCorp. LabCorp will respond with a fax including the time and location for the scheduled test. Parents will receive a letter from Bright Start informing them about the appointment. Parents will receive test results directly from LabCorp. The parents will also receive a Paternity Affidavit, although the parents still decide whether or not to establish paternity.

After consulting with attorneys and DCS staff, Bright Start determined that LabCorp will not notify DCS about test results, contrary to the wishes of many prosecuting attorneys. Bright Start will, however, receive a report from LabCorp with test outcomes for evaluation purposes only. The program hoped that this procedure would allay the concerns of parents who might not understand the difference between Bright Start and child support enforcement.

Identifying convenient testing locations proved the most difficult aspect of providing genetic tests. Bright Start anticipates that many program participants will face significant financial and time constraints; any amount of travel may

prevent them from appearing for an appointment. For the parents' convenience, Bright Start asked hospitals' labs to perform the tests but several refused. Because the procedure is not complicated, Bright Start has explored other possible sites, including a DCS field office and birthing center offices. The program has established sites convenient to all Bright Start areas except Yakima and Toppenish as of June, 2006.

OTHER COMMUNITY PARTNERS

Bright Start intends to expand the number and type of locations offering program materials over the course of the grant based on the initial response to the program and on requests from community partners. Several DCS field offices have expressed interest in offering the full range of Bright Start services, and hospitals indicated that presenting paternity information early in a pregnancy would significantly improve the chances for successful paternity establishment. Possible locations include prenatal clinics, WIC offices, and teen parenting classes

REACTIONS TO BRIGHT START

HOSPITALS

As noted above, evaluators spoke with hospital staff about the Paternity Affidavit program as it currently exists as well as their impressions of Bright Start. Although responses varied by hospital, the overall response to Bright Start was positive. Hospital staff were generally pleased with the opportunity to get a refresher course on the Paternity Affidavit process. Some staff were unfamiliar either with the affidavit process (e.g., how long they had to file the affidavit with the state, what materials to present to the patients and their partners) or with the materials DCS provides to support the program.

The meetings allowed Bright Start to clarify how the affidavit program fits within the larger mission of child support, the cost savings to taxpayers associated with the program, and the local resources available to hospital staff who had questions about the process. Staff also found it helpful when local DCS representatives attended the trainings. Staff noted that they often have little contact with DCS, and intermittent refreshers would be helpful in maintaining the program's momentum and helping to familiarize newer staff with the process.

NOTARIES

Responses from hospital staff indicated that 24 hour notary coverage is rare in most birthing centers. However, staff from most hospitals reported that mothers had access to a notary at some point during their stay. Most hospital staff felt that additional notaries would improve their facilitation of paternity establishment.

Bright Start offered to reimburse hospitals for all costs associated with training additional notaries, including the training, bonding, and supplying of each

notary; every hospital requested at least one additional notary. Often, birthing centers wanted additional notaries so they could reduce reliance on notaries from other units in the hospital and from other organizations outside of the hospital. Almost all hospitals requested funding to increase the number of notaries available. Based on input from the trainings, Bright Start anticipates funding training for 40 new notaries (two hospitals had not submitted requests as of June 2006).

EQUIPMENT

Many hospitals noted that their existing audio-visual equipment limited their ability to show the video. Although many hospitals have televisions in every room, some lacked the ability to play VHS tapes or DVDs. Other hospitals had to rely on a limited number of VHS players that have to be carted from room to room. Nearly every hospital requested additional equipment.

As of June 2006, Bright Start had purchased 17 televisions (including DVD/VCR) and rolling carts and four portable DVD players. One hospital plans to provide the video over its in-house television system (if this is not feasible, Bright Start will provide the hospital with three or four televisions).

UPDATED MATERIALS

Many staff had not seen the existing paternity video and appreciated the opportunity to view the updated video during the training sessions. Reaction to the video was generally positive, although one interviewee thought that it needed more Hispanic actors. Others felt that, since many parents found the current video too long, many will miss the description of the Bright Start services. Reaction to the Bright Start pamphlets were similar. Although generally supportive, some staff noted that, despite the sixth grade language mandated by state law, many parents would find the information in the brochures too complex.

PARENTING PLAN

The rationale behind offering parenting plan mediation was well received by hospital staff. One interviewee noted that it puts administratively established child support orders on a level footing with court-ordered establishments. The administrative establishment process does not address custody, access, or visitation rights. The courts handle these issues through a separate process. Access and visitation would, however, be addressed as part of a court-ordered paternity establishment process.

Almost all hospital staff felt that many parents would benefit from a formalized parenting plan. Although parents might be happy and communicative at the time of the birth, they can quickly go separate ways. The parenting plan establishes a role for both parents.

While most were positive about the concept of the parenting plan, many staff questioned whether parents—particularly younger ones—would follow through on the steps necessary to establish a plan. Staff at several hospitals predicted that patients would have trouble understanding the concept, particularly patients with limited English skills. A common concern was that expecting and new parents often do not attend mandatory or strongly advised activities (e.g., prenatal care, child birth classes). Staff thought it was unlikely that many parents, especially younger ones, would enroll in a voluntary activity such as a parenting plan. Moreover, transportation may be a substantial barrier for parents without their own cars.

Staff also questioned whether parents would be thinking ahead to the future. Often parents are happy with each other at the time of the birth and do not anticipate breaking up or moving apart. Some staff indicated that older parents, or those having a second or third child with the same father, might be more receptive to the parenting plan concept.

Finally, almost all staff expected that the filing fee would be a barrier to participating in this service. Still, staff thought it was important to give new parents the booklet, noting that parents could mull over the services after they have adjusted to life with a newborn and begin to think about longer-term issues, such as parenting. Staff from Madigan Army Medical Center shared their concern that the local DRC obtain samples of military medical plans because they have two forms depending on where and when parents are deployed and relocated.

MARRIAGE EDUCATION

Staff expected new parents would be least receptive to the marriage education service although reactions ranged from optimistic that many couples will benefit to highly skeptical that even offering the service is really appropriate. Some of the same issues were raised as with the parenting plan, however (e.g., transportation, time commitment, satisfaction with the state of the relationship). There was general agreement that, as one staff person stated, “Marriage is too far in the future. Parents are in the here and now.” Staff did note that this may be a valuable service for those parents already considering marriage. They suggested that it may be more popular among older, more mature parents.

Staff from several hospitals questioned the wisdom of including marriage education in the video when the program does not have available service providers. John Hoover stated that the decision to include marriage education was based on the cost of producing a new video when marriage education became available.

GENETIC TESTING

As noted above, concern about the identity of the father—by the mother, the grandparents, or the putative father—is a key barrier to signing a Paternity Affidavit. For this reason, hospital staff anticipated that the genetic testing service

would be the most popular of the three Bright Start services, as most hospitals already receive questions about conducting genetic paternity tests. Currently, parents who express an interest in genetic testing must schedule and pay for the test themselves. Low-income parents can rarely afford these expensive tests and may not establish paternity as a result.

Some staff questioned how the service would work if there was more than one possible father. John Hoover indicated that the most likely father should be tested first. Some also expressed concern that fathers would be pressured to acknowledge paternity if the results came back positive. Others worried that the test would give fathers yet another excuse not to sign. In fact, the parents receive the test results and make the determination as to whether to acknowledge paternity or not. If the father chooses not to acknowledge paternity, the State would require him to submit to a second genetic test if and when DCS opens a case for his child, just as they would if he hadn't submitted to the first test.

DCS FIELD OFFICES

DCS field staff expressed enthusiasm for Bright Start. They noted the ability of Bright Start to help alleviate some of the concerns of local prosecutors. Prosecutors have raised the issue that the Paternity Affidavit makes it more difficult for families to address parenting plans and other access and visitation issues. DCS staff hope to increase prosecutors' support for the Paternity Affidavit process now that assistance with a parenting plan is available in Bright Start regions. Staff were ambivalent about the marriage education component. While they felt that these services may be appropriate for some parents, they expressed doubt that many parents would want to participate in these programs.

DISPUTE RESOLUTION CENTERS

DRC directors are enthusiastic about the Bright Start Model. One director noted that fathers are more likely to be involved with the child if there are regularly scheduled visits. This, in turn, affects the well-being of the child. Two of the directors expressed no concern with capacity issues.

The Pierce County DRC director noted that, depending on the diversity of the population, language could be an issue, although staff include Spanish-speaking mediators. Other local non-profits could be contacted if other language needs arise. The Yakima DRC thought a volume of two or three referrals per month would be manageable; more than that might create staffing problems.

Two DRC directors stated that they typically deal with parenting plans in cases involving parents who are getting divorced or who have already divorced but need to amend the plan (e.g., because one parent is moving). Although the DRCs have limited experience developing parenting plans under the circumstances most likely under Bright Start (i.e., never married parents), the Directors were confident that the existing model would work for these clients.

Although the directors spoke positively about the initiative, there were a few common concerns:

- Court filing fees could be an impediment to low-income parents.
- Parents may have good intentions at the hospital but not follow through. The time consuming steps involved in mediation require active participation of both parents. DRC staff questioned whether many parents would follow through with the entire process.
- It is unclear if teenage parents can sign parenting plans. The Tacoma DRC director will look into this.

MARRIAGE EDUCATION PROVIDERS

At the time of this report, Bright Start had yet to begin offering marriage education services. Although it hopes to refer parents to programs being offered in Lakewood and Yakima as part of ACF's healthy marriage initiative, this had not been finalized. Staff from the Yakima initiative have had initial conversations with Bright Start staff, and are eager to serve potential Bright Start clientele. Similarly, The director of the Lakewood initiative is eager to work closely with Bright Start and, in fact, hopes that Bright Start will be a major source of referrals.

PROSECUTING ATTORNEYS

Prosecutors have historically opposed the Paternity Affidavit on a number of grounds, although criticism has diminished over time as Washington's Paternity Affidavit program generates few complaints and will not likely disappear. The prosecuting attorney we interviewed regarding Bright Start, while not incredibly supportive of the Paternity Affidavit, nonetheless reacted somewhat favorably to the Bright Start enhancements. He stated that offering no-cost genetic tests and parenting plan mediation addressed two of the most important criticisms of the existing program. On the other hand, he was not optimistic that Bright Start would have a large impact overall, believing that voluntary paternity establishments occur in "easy" cases that would not generally result with court-ordered paternity establishment.

CONCLUSION

Washington's innovative paternity affidavit program gained national attention after its debut in July 1989. Based largely on recommendations from the Governor's Efficiency Commission, the program quickly surpassed the Commission's projections for hospital-based paternity establishments. Hospitals currently generate over 70% of all paternity affidavits filed in Washington. Voluntary paternity acknowledgements divert paternity cases from the court system, saving the courts and the child support enforcement system a significant amount of resources. Largely as a result of Washington's success, the federal Omnibus Budget Reconciliation Act of 1993 mandated that all states implement similar voluntary paternity acknowledgement programs.

Control of the program devolved to the DCS field offices in 1995, reducing state oversight of the program. Despite these changes, the statewide paternity establishment rate has continued to improve. Some DCS employees have, however, displayed concern that the program has been on "autopilot," and that the program would benefit from a renewed effort to improve hospital performance.

In mid-2005, the federal Office of Child Support Enforcement awarded Washington State a Section 1115 demonstration grant to implement and rigorously evaluate enhancements to its pioneering work in voluntary paternity establishment. The demonstration, called Bright Start, seeks to overcome barriers to paternity establishment using two major strategies: strengthening the delivery of the existing paternity affidavit program and expanding the range of services associated with the program to include no-cost (to the mother and putative father) genetic testing, mediation services to develop parenting plans, and marriage education to interested parents. Beginning in April 2006, DCS implemented Bright Start in four of the ten DCS catchment areas. Although the Bright Start regions have somewhat lower paternity establishment rates than the state as a whole, the diversity of birthing hospitals in these regions displays the spectrum of paternity establishment procedures.

This report describes the range of paternity establishment practices in Washington, the changes implemented by the Bright Start demonstration grant, and the reaction of program partners to the Bright Start enhancements. Site visits and interviews with hospital staff, DCS employees, Bright Start service providers, and other program partners produced a picture of the current paternity affidavit program, perceived barriers to attaining additional acknowledgements, and the potential benefits of the Bright Start enhancements.

CURRENT PRACTICES

Parents can establish paternity administratively, through voluntary acknowledgement, or through the courts. A parent may independently request that

the courts establish paternity for a child. In most instances, however, the court orders paternity establishment when an unmarried mother files for child support or applies for TANF. At present, voluntary acknowledgements make up the vast majority of all paternity establishments, and the majority of these acknowledgements originate from hospitals.

Washington's overall paternity establishment rate has increased, in part as a result of an increasing number of signed paternity affidavits. Statewide, the ratio of affidavits filed to the number of unmarried births rose from 50 to 62 percent between 1996 and 2004. There is, however, wide variation among individual hospitals. Establishment rates at hospitals with over 100 live births per year ranged from 8 to 76 percent in 2003; establishment rates at the smallest hospitals are not particularly meaningful because of the small number of births to unmarried mothers.

Conversations with hospital staff and DCS workers identified challenges to increasing the voluntary paternity acknowledgement rate. These factors vary by hospital but include: program implementation (e.g., when the paternity issue is raised, which staff are involved), notary availability, population demographics (e.g., lack of bilingual staff to work with Hispanic or other non-English-speaking parents), and staff and administrative support for the paternity affidavit program.

THE BRIGHT START DEMONSTRATION PROJECT

The Bright Start demonstration project seeks to enhance Washington's voluntary paternity establishment paternity processes by reducing barriers to successful paternity establishment in hospitals and by offering additional services to encourage paternity establishment among unmarried parents.

Interviews with hospital staff and other program partners revealed strong support for the existing paternity affidavit program and the Bright Start enhancements. Most hospitals requested new video equipment to show the updated paternity video and asked for Bright Start funding to train additional notaries. Staff supported offering no-cost genetic testing to potential fathers. Interviewees also supported the mediation services and marriage education classes, but questioned whether new parents, many of whom are young, would take advantage of these services, at least in the short run. Staff cited time commitments and transportation issues as barriers to using these enhancements.

NEXT STEPS

This report is the first phase of the Bright Start evaluation. When the demonstration concludes in June 2008, the evaluation team will expand this study to a complete evaluation of program processes from inception to conclusion. In addition to an updated process study, the evaluation will include an impact study that will estimate the independent effect of Bright Start on rates of voluntary paternity establishment and a participation study that will measure demand for the program's enhanced services.