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Dads on the Dotted Line: A Look at the In-Hospital Paternity Establishment Process

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Introduction

Between 1980 and 2012, the proportion of nonmarital births in the United States doubled. Today, more than two out of five U.S. births are to unmarried mothers. This dramatic rise in the number of nonmarital births is a concern not only because of the increased risk of negative child outcomes associated with nonmarital childbearing, but also because these children do not have a legal father until paternity is established. Paternity establishment legally certifies the father as a biological parent, and affirms his legal rights and responsibilities to the child. In addition, paternity establishment is associated with a host of positive outcomes for children—especially when completed voluntarily in the hospital.

Prior research has shown that fathers who voluntarily establish paternity in the hospital are more likely to be involved in their children's lives than fathers who establish paternity elsewhere or not at all.¹ Higher levels of father involvement, in turn, are associated with a range of beneficial child outcomes, including improved cognition, language development, and emotional regulation.²⁻⁴ Fathers who voluntarily establish paternity in the hospital are also more likely to support their children financially than fathers who establish paternity elsewhere or not at all.^{1,5,6} A number of studies have shown that children who receive regular child support from their fathers experience fewer behavioral problems, greater academic achievement, and reduced rates of depression, anxiety, and low self-esteem.⁷⁻⁹

Given the steady rise in nonmarital childbearing and, by consequence, the growing importance of paternity establishment, the last three decades have seen the introduction of a number of laws and regulatory changes within state child support divisions intended to simplify and promote voluntary paternity establishment at the birth. From 1988 to 2013, the proportion of nonmarital births with paternity established (or paternity establishment percentage (PEP)) rose from 31 percent¹⁰ to 94 percent,¹¹ with the vast majority of unmarried parents now establishing paternity in the hospital voluntarily. These achievements notwithstanding, few researchers have examined the process of paternity establishment itself to determine whether it is working as intended, or whether gains in the rate of paternity establishment have come at the expense other policy goals. Little is known about the perspectives of unmarried parents at the center of the process, including whether they adequately understand its implications, and why some choose to establish paternity while others do not. Similarly, little is known about the views of hospital staff who administer the process, and whether current institutional systems contribute to or inhibit effective paternity establishment practices. A better

understanding of the successes and challenges surrounding in-hospital paternity establishment may lead to improvements in this important legal procedure that result in a process that is of higher quality, more accurate, and better tailored to the needs of parents, hospitals, and staff.

To address these topics, this paper uses original data collected through two separate studies in Texas. As a large and diverse state with consistently high rates of voluntary paternity establishment, Texas offers a useful case study for understanding the paternity establishment process and likely carries findings applicable to other states with similar processes. The first study is a longitudinal birth cohort study of approximately 800 Texas mothers who gave birth outside of marriage in January 2013, known as the Paternity Establishment Study (PES). The second is an online survey of 555 hospital staff certified to register births in Texas (known as birth registrars), conducted in January of 2014 and known as the Nonmarital Birth and Registration (NBAR) study. To lend greater context to our quantitative findings, we also integrate themes from a roundtable discussion with staff from the Texas Child Support Division who oversee in-hospital paternity establishment processes across the state. Together, these data provide a wealth of new information on the paternity establishment process, and through varying perspectives permit a more holistic rendering of the circumstances surrounding the legal affirmation of fatherhood.

We examine the process of voluntary paternity establishment from two perspectives—that of unmarried parents and that of birth registrars certified to administer the process. Distinct from much of the prior work on paternity establishment, we focus on the context of the process itself rather than the characteristics of those who establish paternity or do not. Specifically, we ask: 1) what are the primary duties, training, and levels of experience of birth registrars?; 2) are birth registrars supported in their roles from hospital staff, nurses, and the Child Support Division?; 3) what do birth registrars identify as the major obstacles to establishing paternity in-hospital?; and 4) to what extent do birth registrars understand parents' reasons for establishing or not establishing paternity in the hospital?

Background

In the United States, more than 1.5 million children are born to unmarried parents each year.¹² One of the first events in these children's lives is the registration of their birth and the creation of their birth certificate—the establishment of their individual legal identity and proof of the details of their birth. Unmarried mothers have their names on the birth certificate and are legally attached to their children without further action, but an

unmarried father's paternity must be established for him to be recognized as the child's legal parent.

Paternity can be established through a voluntary process or through court order. Voluntary paternity establishment, which in Texas is usually accomplished by signing an acknowledgment form in the hospital at the time of birth, is the dominant method of establishing paternity. Approximately 70 percent of unmarried parents in Texas assign paternity in this way, and research suggests the percentage is considerably higher when the father is present at the hospital.¹³

The Importance of In-Hospital Paternity Establishment

The voluntary paternity establishment process that is administered by hospital professionals has various advantages. Establishing paternity in the hospital is fairly simple and can be done before or after the birth of a child, and it does not require evidence of paternity (e.g. DNA testing).¹⁴ In the majority of cases, voluntary paternity establishment requires both parents to sign a form at the time of birth registration, legally certifying that the mother and father acknowledge that the father is a biological parent of the child.

Paternity establishment is also linked to a number of legal and symbolic benefits. One immediate and tangible reason for establishing paternity in-hospital is the right of fathers to include their name on the child's birth certificate. Paternity establishment also ensures that children born outside of marriage are eligible for a wide range of benefits through their fathers, including health insurance, life insurance, social security, veteran's benefits, and inheritance.¹⁴ For children born to unmarried parents, an additional benefit of paternity establishment is the ability to access their paternal genetic history and determine if they may be at risk for any inherited health defects. Finally, establishing paternity is a necessary precondition for formal child support or the establishment of legal visitation orders.¹⁴

In addition to the many legal benefits, establishing paternity symbolizes a direct connection between a father and child. Formalizing this connection lays the groundwork for future father involvement and support, both of which have been linked to numerous positive child outcomes. Nonresident fathers who voluntarily acknowledge paternity in the hospital are more likely to comply with child support orders than those fathers who do not.⁵ Moreover, fathers who establish paternity in the hospital are also more likely than fathers who establish paternity outside the hospital, or not at all, to be involved in their child's life through frequent contact and overnight visits.¹ Though voluntary paternity establishment is

associated with greater paternal involvement and support, it is important to acknowledge that these patterns may be at least partially explained by selection; that is, the same characteristics associated with fathers who establish paternity are also associated with higher levels of involvement and support. Regardless, voluntary paternity establishment is still widely considered to be beneficial for children in most circumstances given its extensive legal advantages.

Perhaps unsurprisingly, researchers have noted that voluntary paternity establishment in the hospital shortly after birth is likely the best time for fathers to establish legal fatherhood.¹⁵ First, completing the paternity establishment process in the hospital is convenient for parents because it is probable that both parents will be present to sign the form.¹³ Second, creating the birth certificate with both parents' names from the start saves time and difficulty for the state and for parents. Finally, and perhaps most importantly, fathers become less likely to voluntarily establish paternity over time following a nonmarital birth.¹⁶

Though conventional wisdom would suggest that all unmarried parents establish paternity in the hospital, best practice may vary under different circumstances. For parents who are in highly committed relationships, establishing paternity during pregnancy may be ideal. In cases of family violence, on the other hand, the preferred method of paternity establishment may be through the court system, where legal parameters can be placed on parents' visitation access to the child. Signing in the hospital, however, remains the most common method of paternity establishment; 74 percent of unmarried parents in Texas established paternity in the hospital in 2012.¹⁷

Legal & Historical Background of In-Hospital Paternity Establishment

Lawmakers have long recognized the benefits of paternity establishment; in fact, since the enactment of Title IV-D of the Social Security Act in 1975, federal legislation has provided much of the impetus for change in paternity establishment policies in hopes of increasing paternity rates. Congress enacted the Family Support Act in 1988 to revise and strengthen existing AFDC policies around work, child support, and family benefits. The primary components of this act included setting incentives for states to establish paternity, requiring states to use genetic testing in cases of contested paternity, encouraging states to use civil processes for establishing paternity, and allowing for paternity to be established at any point before a child's eighteenth birthday.

In 1993, Congress enacted the Omnibus Reconciliation Act, which required states to create a simplified administrative process for parents to

voluntarily establish paternity in the hospital at the time of their child's birth. As these policies gained traction, studies reflected their success; in-hospital paternity establishment interventions in Colorado, for example, effectively doubled voluntary paternity acknowledgment rates in four Denver hospitals.¹⁵

The voluntary paternity acknowledgment process was also enhanced by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. Through PRWORA, Congress increased the paternity establishment standard for states from 75 percent to 90 percent of all births to unmarried mothers. In addition, Congress required unmarried parents to sign a voluntary acknowledgment of paternity for the father's name to be identified on the child's birth certificate.¹⁸

Two additional developments have helped incentivize states to increase the rate of in-hospital paternity establishment. The first is a set of federal performance measures enacted under the Child Support Performance and Incentive Act of 1998. As one of these measures, the rate of paternity establishment for nonmarital births has become a critical metric for states seeking federal incentive funds. The second incentive is internal to state child support offices. Since paternity establishment is a necessary prerequisite for child support, achieving a higher rate of in-hospital paternity establishment effectively expedites the establishment of subsequent child support orders. In this way, state agencies are naturally motivated to increase the percentage of parents who voluntarily establish paternity in-hospital in order to obviate future barriers to child support filing.

Together, these incentive structures and policy modifications have led to national and state increases in paternity establishment rates. In 1988, the paternity establishment rate for the U.S. as a whole was approximately 31 percent.¹⁰ By 2013, the proportion of nonmarital births with paternity established had climbed to 94 percent,¹¹ with the vast majority of unmarried parents establishing paternity in the hospital voluntarily.¹⁹

The Birth Registration Process

Though the process of birth registration and paternity establishment varies slightly across states, all states offer unmarried parents a chance to voluntarily acknowledge paternity in the hospital. This legal process is completed by signing a form, known in Texas as the Acknowledgment of Paternity (AOP) form. Though other states may use a different name—for example, the Acknowledgment of Paternity Affidavit in Ohio, or Paternity

Acknowledgment form in Florida—the legal consequence of this process is functionally the same.

The Texas Administrative Code stipulates that all public and private birthing hospitals and birthing centers *must* provide voluntary paternity establishment services after being certified by the Texas Office of the Attorney General.²⁰ This legal obligation compels hospitals and birthing centers to designate staff to provide paternity establishment services. The certified staff who fulfill this role, typically referred to as birth registrars, are responsible for guiding parents through the AOP process and, when appropriate, obtaining the signed document certifying legal fatherhood. Given the long-term consequences of this process, it is critical to understand the role of birth registrars in facilitating or frustrating its success. Birth registrars are typically not attorneys, and though they are provided with training and state-mandated oversight, questions remain as to whether they possess adequate levels of education, experience, and support to handle the often sensitive legal complications associated with paternity establishment. Concerns have also been raised about the robustness of the AOP certification process, and whether the large number of staff distributed across a large number of hospitals leads to quality control issues.²¹ A primary goal of this paper is to shed light on these and other topics, including who birth registrars are, what their workload entails, their levels of preparation, the degree to which they feel supported in their work, and their effectiveness in working with parents.

Examining the In-Hospital Paternity Establishment Decision

Recent studies on in-hospital paternity establishment have primarily concentrated on understanding the characteristics of those who establish paternity in the hospital, those who establish paternity elsewhere, and those who do not establish at all. Less research has been done on why parents establish paternity, or whether the process itself is operating effectively in the wake of federal policy changes requiring voluntary acknowledgment programs in all hospitals and birthing centers.

In one of the first rigorous, large-scale studies devoted to paternity establishment, Mincy et al finds that fathers who have more than a high school education, were employed prior to the birth, and do not have children from previous relationships are more likely to establish paternity in the hospital than fathers without these characteristics.¹ Fathers are also more likely to establish paternity in the hospital if they display altruistic behaviors during the pregnancy (e.g., contributing cash or in kind support during pregnancy, or demonstrating emotional support of the mother).¹

The biggest determinant of in-hospital paternity establishment, however, is the baseline status of the parental relationship. Couples who are cohabiting, romantically involved, or in friendly relationships are considerably more likely to establish paternity in the hospital than parents with little or no contact at birth.¹ These patterns are confirmed by Guzzo who shows that couples cohabiting at birth are not only more likely to establish paternity, but are much more likely to do so in the hospital relative to establishing paternity elsewhere.¹⁹ This association holds for both first and subsequent births.

Research on the connection between in-hospital paternity establishment and fathers' demographic characteristics is somewhat less consistent. When controlling for other characteristics, Mincy et al finds no association between in-hospital paternity establishment and a father's race/ethnicity or age.¹ In contrast, Guzzo finds that Hispanic and Black fathers are significantly less likely than White fathers to establish paternity for first births through any method.¹⁹

Research on *why* fathers establish paternity is far more limited. Despite a plain need to understand what motivates parents' paternity establishment decisions, few studies have examined this topic directly. A descriptive analysis of mother and father survey data, however, shows that for most parents—and especially those in cohabiting or dating relationships—the decision to establish paternity is largely a symbolic and emotional one, guided more by what it *means* than what it *does*.²²

Prior Research on Paternity Establishment Policy

Research on the in-hospital paternity establishment process mostly predates the current policy landscape. Studies from the early 1990s largely endorsed congressional efforts to increase the rate of paternity establishment.^{23,24} In 1993, four Denver hospitals began piloting an in-hospital paternity establishment program that would result in dramatic increases to the paternity establishment rates in those hospitals, and help reinforce federal efforts to make voluntary acknowledgment programs universal.¹⁵ Several years later, Sorensen and Oliver evaluated changes in the paternity establishment percentage in 13 states following modifications made under PRWORA in 1996, and found that between 1996 and 1998, the majority of states experienced an increase in their paternity establishment percentages while only one state experienced a decrease.²⁵ Other research has questioned the integrity of the in-hospital paternity establishment program, suggesting that, in the quest for federal incentive payments, states have been incentivized to jettison paternity accuracy in pursuit of higher paternity establishment rates.²¹ Some have

argued that the Texas Family Code fails to compel full disclosure from the mother, and effectively leaves open the possibility for the wrong father to establish paternity, either through persuasion from the mother, pressure from hospital staff, or lack of understanding as to the gravity of the commitment he is making.²¹ It should be noted, however, that either parent can rescind paternity by filing a petition in court within 60 days of the date that the AOP was filed with the Bureau of Vital Statistics.²⁶

One recent study conducted in Texas suggests that an often overlooked element in the paternity establishment process is whether or not the father is present at the birth. Prior thinking on the in-hospital paternity establishment decision has largely cast fathers who do not establish paternity as willful objectors, actively declining to sign the legal paternity paperwork presented to them in the hospital. In reality, however, most fathers who do not establish paternity are not present in the hospital when the paperwork is presented. In fact, when the father is in attendance at the hospital, nearly 90 percent of parents voluntarily establish paternity.¹³ The finding that birth registrars are securing a voluntary acknowledgment of paternity nearly every time both parents are present at the hospital suggests the process may be even more “successful” than previously thought. On the other hand, there remain concerns about whether it is appropriate to measure the success of in-hospital paternity establishment programs purely by the percentage of parents who sign the form. A more complete measure of success would almost certainly include whether paternity is being established accurately (for the biological father), whether parents understand what they are signing, and whether, in some cases, it may be more appropriate to establish paternity through the court system where additional legal parameters can be put in place alongside legal paternity. In effect, the process must be deliberate in purpose, but also malleable in form in order to ensure that it is effective for the broad and heterogeneous population it touches. This paper extends prior research on the in-hospital paternity establishment process, as well as the motivations behind parents’ decisions, by incorporating voices from both sides of the process—birth registrars and unmarried parents.

Method

This paper employs both qualitative and quantitative data to analyze the factors influencing the work of birth registrars and the unmarried parents they serve. The bulk of our findings rely on an online survey of birth registrars (NBAR), and an in-person roundtable discussion with the Texas Office of the Attorney General (OAG) staff who oversees birth registrar training and certification. Additionally, we incorporate data from the

Paternity Establishment Study (PES) study, a representative statewide survey of unmarried parents, to compare the experiences and attitudes of unmarried parents with those of birth registrars.

As noted previously, Texas serves as the case study for our research aims. Though the in-hospital paternity establishment process varies from state to state, the general purpose, circumstances, and legal implications are the same. As one of the largest and most diverse states in the country, Texas may be well-suited for a generalizable study in this area. In 2012, Texas accounted for nearly 10 percent of births in the U.S.¹² moreover, the demographic composition of the state is reflective of developing trends in U.S. demographics overall. In addition, the state has posted relatively high and consistent rates of voluntary paternity establishment, with 74 percent of unmarried parents establishing paternity in the hospital in 2012.¹⁷

Data

Nonmarital Birth & Registration Survey (NBAR)

The Nonmarital Birth and Registration (NBAR) survey was developed to inform the four research aims discussed in this paper. The survey was conducted online in January 2014 among all hospital staff certified in the paternity establishment process across Texas.

Examples of topics covered in the NBAR survey include demographic characteristics of birth registrars, workloads, support from hospital staff and management, and views about parents and the AOP process. The population consisted of 1,481 email addresses, 52 of which were undeliverable because of an incorrect email address, and one which opted out. In total, 588 individuals completed the survey, resulting in a 41 percent response rate during the two-week period in which the survey remained open. The sample was limited to individuals whose AOP-certification had not expired, reducing the final number of respondents to 555. Of those 555 individuals, 173 (31%) are full-time birth registrars while the remaining 69 percent are certified to register births but work primarily in other capacities.

In 2012, the OAG reported receiving birth data from 273 hospitals or birthing entities, the majority of which have one or fewer full-time birth registrars. NBAR received responses from AOP-certified staff at 219 hospitals or birthing entities, including 109 hospitals in which at least one birth registrar completed the survey. Altogether, NBAR includes responses from staff at over 80 percent of birthing hospitals, and a likely majority of all full-time birth registrars.

As a group, the birth registrars in our sample are largely White or Hispanic, with either some college or a college degree [Table 1]. They are almost entirely female, and the median age is 43. There are some differences among birth registrars, however, depending on their specific job title (not shown). Some birth registrars (e.g., full-time birth registrars) spend the vast majority of their time registering births, whereas others have management, administrative, or nursing duties that make up the majority of their time. Those whose primary responsibility is to register births are more likely to be Hispanic or Black, more likely to be bilingual (usually Spanish), and less likely to have a college degree, than the administrative or medical staff who register births more infrequently (not shown).

Table 1. NBAR & PES Sample Demographics

NBAR and PES Sample Demographics		
	NBAR (Birth Registrars)	PES (Unmarried Mothers)
<i>N</i>	555	800
<i>Gender</i>		
Female	98%	100%
<i>Race/ Ethnicity</i>		
White, Non-Hispanic	46%	26%
Hispanic/Latino	38%	56%
African American/Black	12%	14%
Other	4%	4%
<i>Education Level</i>		
Less than high school	0%	19%
High school or GED	18%	30%
Some college	44%	41%
College degree or higher	38%	10%
<i>Age</i>		
Median Age	43	24
<i>Bilingualism</i>		
Fluent in Language other than English	39%	NA

Source: NBAR Survey; PES Mothers at 3 Months, weighted.

Paternity Establishment Study (PES)

The Paternity Establishment Study (PES) was developed to provide information on the parental characteristics and prenatal factors associated

with parents who establish paternity in-hospital and those who do not. Examples of topics covered in the survey include demographic and socioeconomic characteristics of parents, relationship dynamics, father involvement, multipartner fertility, parental care, paternity establishment experiences, and intent to obtain a child support order.

Data from the PES study were collected through a stratified random phone and email sample of unmarried Texas parents who gave birth during a two-week period in January 2013. The survey was administered online and by phone during a two-month period beginning in April 2013, when the target child was approximately 3 months old. It was offered in both English and Spanish to a final sample of 800 Texas mothers and 286 Texas fathers. Ideally, both mother and father survey data would inform this analysis; however, too few fathers completed the survey to constitute a representative sample. As a result, analyses in this study rely solely on mother reports.

The PES sample is drawn from separate strata consisting of hospitals or birthing entities such that all geographic areas of the state are represented in accordance with their relative proportions of nonmarital births. Mothers were first sorted into two groups within each stratum—those who established paternity voluntarily, and those who did not. Within each stratum, mothers were randomly selected from each establishment group; mothers who did not establish paternity were oversampled. If a randomly selected mother had incomplete contact information in administrative records, a second (or more) mother was selected from that stratum and establishment group. Overall, only 46 percent of randomly selected mothers could be reached. Among mothers who could be reached, the overall refusal rate was 1.8 percent. Mothers missing contact information did not differ considerably by geographic location, but mothers who did not establish paternity were less likely to have complete information than mothers who established paternity.

As noted, the sampling methodology oversampled unmarried mothers who did not sign the AOP in an effort to improve the reliability of estimates calculated for this subgroup. Though sample sizes (*N*) presented throughout this paper are based on this unadjusted sample, all analyses have been weighted to reflect the true proportions of relative subgroups in the population.

The sample demographics of PES mothers largely mirror the demographics of unmarried mothers in Texas, the majority of whom are Hispanic (58%).²⁷ In general, however, PES mothers are more educated and slightly older than unmarried mothers in Texas at large.²⁷ These discrepancies may be due to non-response bias or missing contact

information for mothers in the sample. Compared to the demographic composition of unmarried mothers in the U.S., Texas is more Hispanic and younger.²⁷ Population projections for the U.S., however, increasingly mirror the current demographic makeup of Texas.^{28,29} In comparison to birth registrars, mothers in the PES survey are considerably younger, more likely to be Hispanic, and generally less educated.

Roundtable Discussion with Paternity Outreach Coordinators

To lend greater context to survey data presented in this paper, we also draw on a three-hour roundtable discussion with Paternity Outreach Coordinators (POCs) from the nine child support regions in Texas. Paternity Outreach Coordinators are employed by the Texas Office of the Attorney General's Child Support Division, and are responsible for training birth registrars and overseeing the Paternity Opportunity Program in certified hospitals across the state. The roundtable discussion was held on December 10, 2013, and included topics such as the day-to-day operation of the Paternity Opportunity Program, training of birth registrars, difficulties facing hospitals, birth registrars and POCs, common questions received by POCs, and the overall successes and challenges of the program. Four researchers transcribed notes from the discussion, and aggregated findings based on common themes. Findings from this discussion group are woven throughout the findings to aid in the interpretation of survey data and help paint a richer and more nuanced portrait of the process.

Analytic Strategy

In an effort to provide a broad overview of the voluntary in-hospital paternity establishment process, this paper relies primarily on descriptive and qualitative analyses of data collected through surveys and discussion groups. This mixed method approach permits us to sketch a more comprehensive portrait of the process, rather than test a specific hypothesis or dissect a narrow research question.

Data from the NBAR and PES surveys are presented as summary statistics, distributions, and cross-tabulations. In some cases, percentages are discussed in the text without an attendant table; this is often because the data lend themselves to a linear narrative, and fail to conform to a unified theme that would facilitate a common table. Where possible, we provide comparisons between the NBAR and PES survey populations to demonstrate the degree of divergence on similar questions. Because tabulations are derived from separate samples, we do not provide tests of statistical significance in these instances.

In addition to descriptive statistics, we employ qualitative methodologies to a number of open-ended survey responses from the NBAR study. Open-ended responses are coded based on common themes, aggregated, and rank-ordered by frequency where possible. We also incorporate thematic analyses from the three-hour roundtable discussion with POCs.

Results

We begin by examining birth registrars' primary duties, levels of experience, and training. Because birth registrars are the front-line staff charged with executing the important legal process of paternity establishment, their ability to carry out their roles effectively may influence parents' decisions to sign. Because paternity establishment carries such long-term consequences for parents and their children, birth registrars need to be able to handle a number of complex legal and interpersonal issues that may arise. Training, length of tenure, and other job duties all may affect their ability to effectively navigate these dynamics.

Occupational Characteristics

Many hospital staff holds AOP certification, regardless of whether they regularly interact with parents or provide AOP services. Among those who are certified to register births and guide parents through the AOP process, there is an array of job titles, including birth registrar, nurse, health information manager, social worker, and midwife. Though data from the NBAR survey include all AOP-certified staff, these staff work in diverse roles and perform a wide range of duties. The most fundamental distinction is between those who register births as their primary job duty, and those who perform this task as a secondary role. Between these two groups of certified individuals, there is substantial variation in experience with birth registration and the AOP.

Approximately one-third of the certified staff who completed the NBAR survey hold the job title of birth registrar. For this group, registering births and assisting unmarried parents with the AOP are primary responsibilities and account for the majority of their time. Though birth registrars make up a minority of certified staff in the state, they register the vast majority of births. When asked to estimate the percentage of births that they personally register at the hospital where they work, the majority of birth registrars (62%) report personally registering more than three-quarters of the births. The high volume of births registered by this group means that most hospitals employ only a handful to serve the steady stream of new births. Nearly nine out of ten hospitals have three or fewer

full-time birth registrars on staff; approximately 90 percent of hospitals also have at least one full-time birth registrar on staff. Though birth registrars are typically responsible for registering births to both married and unmarried parents, a small proportion of hospitals—roughly 10 percent—have a position dedicated solely to registering AOP-indicated (nonmarital) births.

Unlike birth registrars, the majority of hospital staff certified to administer the AOP in Texas performs this role as a secondary or auxiliary duty. Though these individuals are trained and certified to execute the same functions as birth registrars, they work primarily in other capacities and may only rarely interact with parents or facilitate the AOP process. Data from the NBAR survey indicate that nearly two-thirds of these staff work in health information management, while 28 percent occupy other administrative roles, and 7 percent work in nursing or patient care. For these individuals, birth registration and AOP duties make up a small fraction of their overall workload; 81 percent of other certified staff report that taking parents through the birth registration process accounts for a quarter or less of their overall job responsibilities. Moreover, other certified staff is much less likely than birth registrars to feel that they administer a substantial share of the registration duties at their hospitals. In the NBAR survey, a majority of other certified staff (54%) say that they personally register a quarter or fewer of the births where they work.

Because other certified staff do not regularly complete AOPs or interact with parents, they are less likely to influence the AOP process or its desired results than birth registrars. Nearly all birth registrars (94%), for example, reported helping parents to complete an AOP in the last week, but only half of other certified staff had done the same. Even more striking, 30 percent of other certified staff had not taken unmarried parents through the AOP process even once in the last month.

Not only do birth registrars and other certified staff differ in their primary job duties, they also differ in their hourly pay. Though the average hourly wage reported for all certified staff in the NBAR survey is \$15.34, with earnings ranging from \$8 to \$40 per hour, birth registrars' wages tend to be lower and less varied. Birth registrars make an average of \$14.31 per hour, compared to \$15.95 for other certified staff. In roundtable discussions, Paternity Outreach Coordinators (POCs) suggested these generally low wages contribute to ongoing challenges with staff turnover, especially given the high-stress, high-workload nature of birth registration.

Moving forward, we present survey data from all hospital staff certified to administer the AOP in the state of Texas as a single group. Though these individuals have different job titles and varying levels of

exposure to the AOP process, they are equally responsible for its administration and are therefore treated collectively as stewards of the Child Support Division's legal mandate to provide in-hospital paternity establishment opportunities across the state. For purposes of simplification, we refer to this collective group of certified staff as "birth registrars," unless otherwise indicated.

Birth Registration Duties

When birth registrars arrive at a new mother's hospital bed to register a birth and provide the opportunity to sign the AOP, they must often compete with the side effects of medicines, high emotions, and the presence of relatives. Moreover, administering the AOP is only one step in the larger birth registration process, and must be completed in concert with other work. In Texas, the birth registration process usually requires completing the following tasks: 1) Filling out the mother's worksheet and mother's medical data worksheet; 2) Assisting parents with completing the ImmTrac Immunization Registry consent form; 3) Assisting parents with completing the AOP (if they are unmarried); 4) Completing the Verification of Birth Facts worksheet; 5) Assisting parents with correcting any errors before submitting the data; 6) Obtaining parents' signatures; 7) Providing Social Security notification letter to parents; and 8) Delivering the OAG parent survey if parents are unmarried.³⁰ Once the birth registrar has completed all steps in the birth registration process, another authorized staff member must certify the information that was recorded, and the forms must be submitted electronically to state and federal agencies.

Though part of the larger birth registration process, completing the AOP, specifically, requires collecting parents' personal information, reading and explaining the purpose and particulars of the AOP form, responding to parents' questions and doubts, and administering a survey that asks parents to confirm they have been given the opportunity to sign. This process provides ample opportunity for variation among birth registrars. A birth registrars' experience, knowledge, personality, appearance, accent, or education may all influence parents' decisions about whether to sign.

Because registrars often attend to married births that do not require an AOP, many view the AOP process as additional, sometimes onerous work. At the roundtable discussion, POCs divulged that birth registrars "do a happy dance" when parents are married because that means avoiding the additional "hassle" of AOP-indicated births. In the NBAR survey, nearly two-thirds of birth registrars indicate that the AOP adds an average of between 15 and 30 minutes to the birth registration process. When

situations are more complicated, the process can take much longer. More than 3 in 10 birth registrars report that complex situations involving the AOP usually add more than an hour to the birth registration process, though on average, birth registrars feel that complicated AOPs tend to lengthen the process by roughly 40 minutes. Birth registrars perceive this extra time as cumbersome; nearly all birth registrars (98%) in the NBAR survey agree that registering a birth for unmarried couples is more work than registering a birth for married parents, and 42 percent feel that it is “much more work.”

Training & Staff Tenure

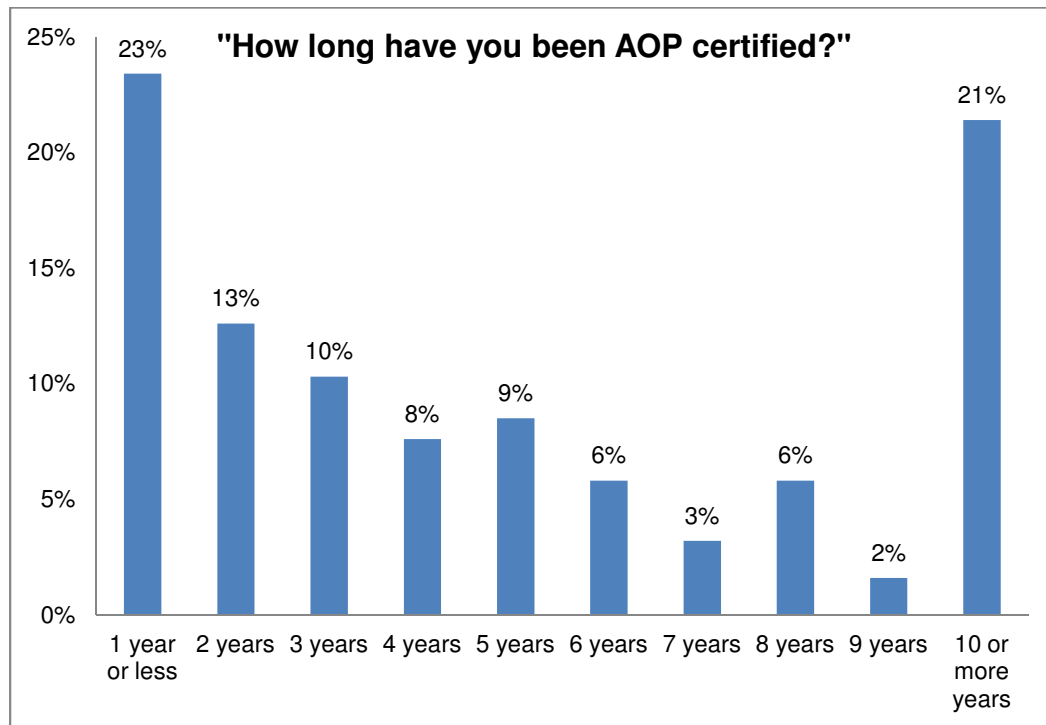
Before assisting unmarried parents with the paternity establishment process, both birth registrars and other certified staff must first be trained and authorized by the Texas OAG’s Paternity Opportunity Program (POP). This program is operated through nine regional offices, each staffed with Paternity Outreach Coordinators (POCs) who train, monitor, and evaluate hospitals’ administration of the AOP. To become certified, hospital staff must undergo an initial in-person training—usually one-on-one with a regional POC—followed by a yearly recertification process, which may be completed either in-person or online. This decentralized approach lends a certain flexibility to the frequency and focus of AOP trainings, permitting regional POCs to provide personalized instruction and guidance in response to the hiring needs of hospitals. Nonetheless, the regionalized nature of the program also introduces inconsistencies. Roundtable discussions with regional POCs, for example, revealed that staff questions regarding unusual circumstances or legal grey areas sometimes lead to conflicting legal directives across regions.

Minor variations in training and guidance notwithstanding, the certification and recertification processes ensure that a regular cycle of preparation and monitoring accompanies the in-hospital paternity establishment process. Most staff keep their certification in good standing; when asked about their most recent experience with training, nearly three-quarters of birth registrars in the NBAR survey had completed a certification or recertification in the last six months. Even the best trained staff is likely to require considerable time on the job, however, before becoming comfortable and effective in their roles.

To understand birth registrars’ level of experience, the NBAR survey collected data on the length of time staff have been certified to administer the AOP. As shown in Figure 1, most staff have been certified for either a very short or very long amount of time. Nearly a quarter have been administering the AOP for a year or less, and a majority has been

engaged in the process for less than four years. A substantial number of certified staff, however, has been on the job for more than 10 years. This bimodal distribution was also noted by POCs, who expressed that most certified staff are either firmly entrenched in their positions (and sometimes difficult to retrain when mistaken) or new to the process (and requiring increased attention to establish best practices).

Figure 1. Length of Certification



Source: NBAR Survey

The finding that nearly one quarter of certified staff have been working in their current capacity for less than a year has implications for training, supervision, and the quality of the AOP process. The high volume of new recruits is suggestive of relatively high turnover, an issue confirmed by regional POCs during discussion groups. This high turnover has cumulative effects on the schedules and workloads of POCs, the OAG staff responsible for training and monitoring certified staff. In roundtable discussions, POCs explained that first time, in-person training is especially time-consuming, and that newly trained individuals often require more assistance and monitoring. Although the Texas OAG now offers recertification training online, the fact that first-time training must be

completed in person makes the cycle of attrition and replacement a continuing concern for POCs. This treadmill of training places significant strain on their time and resources, and reduces their capacity to monitor other aspects of the program. In addition to the structural and management challenges wrought by high turnover, the steady crop of new hires also has consequences for unmarried parents. At any given time, a considerable number of birth registrars will have had little practice administering the AOP, and must navigate what is often a complex and sensitive legal process with limited experience or background on the topic.

Though it is difficult to pinpoint the precise reasons for staff attrition, open-ended NBAR survey responses and POC discussion groups seem to suggest that low wages, high demands, and limited support may be at least partly responsible. In the roundtable discussion, POCs shared that many of the staff they oversee—and especially birth registrars—have extremely hectic schedules and little support from hospital management. They described these factors as strong drivers of turnover. To evaluate the support birth registrars receive from hospital staff and the Texas OAG, we now turn to a discussion of the structural environment, in which birth registrars work.

Support from Hospital Staff & the Child Support Division

Birth registrars must work in concert with nurses, doctors, and the records department to complete the AOP process in a timely and effective manner. The degree to which birth registrars are supported by the nursing staff, their managers, and the overall hospital environment may influence their attitudes, abilities, and levels of stress. Support through continued training, monitoring, and accompaniment by Child Support Division staff (POCs) is also critical to birth registrars' success. In this section, we discuss the relationship between birth registrars and nursing staff, how hospital management views the AOP process, and how birth registrars interact with their regional POCs.

Nursing Staff

Hospital nursing staff can be a key element of support and collaboration for birth registrars. Approximately 83 percent of birth registrars in the NBAR survey report working closely with the nursing staff at their hospital, and nearly all respondents say that the nursing staff are important to their job duties. With such a close working relationship, it is no surprise that nurses are critical to birth registrars' productivity and levels of stress. Three-quarters of birth registrars agree that nursing staff generally make their jobs easier, though in a separate question, 32 percent report that

their job is made harder by a lack of support from nursing staff. Open-ended responses from the NBAR survey also indicate that nursing staff can be helpful points of contact for more complex issues, such as family violence.

Hospital Management

The larger hospital environment sets the expectations and pace of work for birth registrars, a milieu that affects birth registrars' effectiveness in working with parents, as well as their job satisfaction. Roundtable discussion themes made clear that some hospitals are more aware and supportive of the AOP process than others, and that the attitudes of hospital management have strong downstream effects on birth registrars' day-to-day work. To appreciate the typical hospital's perspective on the AOP process, it's useful to first understand the tension between legal requirements to carry out the AOP process and the unfunded cost of doing so. Under Texas law, hospitals and birthing centers are legally obligated to offer in-hospital paternity establishment to unmarried parents,²⁰ without receiving any financial compensation for providing this service. In 2012 alone, more than 160,000 births in Texas were to unmarried parents.³¹ With an average of 15 to 30 minutes added to the birth registration process by each one of these births, the number of unremunerated work hours totals somewhere between 40,000 and 80,000 for hospitals across the state each year. As a result, this compulsory legal process appears, from the hospital perspective, to be a relatively expensive unfunded mandate, resulting in pressure on staff to complete the AOP process efficiently and without complications.

It is worth noting that the particular arrangement in Texas is not shared by all states. The Washington State Division of Child Support (DCS), for example, pays hospitals, birthing clinics, and other entities \$20 for each paternity acknowledgement that is correctly completed and notarized.³² While this system is likely to raise rates of voluntary paternity establishment, it is unclear whether such an arrangement is desirable from a policy perspective. Given the financial incentive for hospitals to increase the number of acknowledgements, some hospitals may encourage parents to establish paternity under circumstances that would be better served through the alternate channels (such as in cases of domestic violence).

In Texas hospitals, a different incentive underlies the paternity establishment process. Because hospitals are not paid per completed AOP, it is in their financial interest to move AOP-indicated births through the system without provoking tension or unnecessarily lengthening the

AOP process. To this end, most hospitals evaluate birth registrars based on general customer service goals rather than more precise measures of effectiveness that may occasionally involve confronting difficult situations. NBAR survey data reveal that nearly 8 in 10 birth registrars are evaluated by their supervisors based on customer service goals, a finding that echoes concerns raised by POCs during the roundtable discussion. When describing the hospital environment, POCs worried that customer service goals may conflict with birth registrars' obligation to make sure parents understand the AOP. This concern is particularly important given that the AOP process involves asking personal questions that may create tension and sometimes upset parents. Rather than risk alienating what hospitals view as customers, POCs fear that birth registrars may shy away from asking necessary and important questions related to the AOP. In the NBAR survey, a striking 23 percent of birth registrars report that service delivery goals prevent them from making sure unmarried parents fully understand the AOP at least some of the time. Somewhat ironically, the customer service goals intended to deliver parents a better experience with birth registration may be unintentionally working against the best interest of parents by preventing them from fully understanding what they are signing.

Child Support Division

Not only do birth registrars work for hospitals, but they also carry out the directives of the Texas OAG's Child Support Division. In this capacity, birth registrars' primary point of contact is their regional Paternity Outreach Coordinator (POC). POCs are the first responders to birth registrars' questions, and they oversee the work and training schedules of all birth registrars in their regions. Texas POCs typically serve a high volume of hospitals and therefore manage a large number of individual birth registrars. Despite the burden these duties place on POCs, birth registrars voice almost unanimous satisfaction with their regional POCs; fully 98 percent of birth registrars in the NBAR survey agree that they receive adequate support from their regional coordinators.

POCs' success in guiding the large and diffuse operations within their regions is made more impressive by the fact that they are trained on the job and have no centralized authority structure. In the absence of a central authority, POCs communicate with one another ad hoc in order to provide information that is as consistent as possible whenever questions arise. As an example of the type of regional variation that occurs, POCs point to complications surrounding third-party AOPs, a special case arising when the mother is or was recently married to someone who is not the

child's biological father. Without a central legal authority to consult in complex cases, POCs in Texas give varying answers and directives regarding how to handle incorrectly-completed third-party AOPs. In roundtable discussions, POCs noted that regional legal counsel have given conflicting guidance on the correct protocol for cases in which parents conceal their marriage status and incorrectly sign an AOP, or when a partial AOP is completed. These variations prevent birth registrars from receiving clear and accurate information when complications arise during the AOP process. In short, though regional POCs appear to be a trusted source of support for birth registrars, POCs themselves may not have adequate support structures within the Texas Child Support Division.

Obstacles to In-Hospital Paternity Establishment

Having detailed birth registrars' job duties, length of tenure, and structural support, we now turn to an exploration of problems that arise from the paternity establishment process itself. Results are derived from both closed- and open-ended NBAR survey questions that ask birth registrars to identify the issues that most commonly complicate the process, pose challenges for parents, or prevent paternity establishment altogether. Because these obstacles are largely procedural, many might be anticipated or avoided through improvements in legal language, changes in staff scheduling, or minor adjustments to policies. Among the challenges cited by registrars, the three most common are third-party AOPs, father availability, and lack of identification. Other challenges are individually less common, but often overlap. These challenges include cultural, educational, and language barriers; concerns about the legal ramifications of signing; difficulty interpreting the legal language of the AOP; doubts about paternity; interfamilial disagreements or relationship issues; and undocumented parents' fear of signing the AOP. All of these concerns are detailed in Table 2 and discussed below.

Table 2. Common Issues Encountered During the AOP Process

<i>Common Factors Complicating or Lengthening the AOP Process</i>	
<i>Most common issues (20-30% of respondents)</i>	
Third-party births	<i>The mother is or was recently married to someone who is not the child's biological father</i>
Father availability	<i>Father's schedule does not align with the schedule of birth registrars</i>
Identification	<i>Lack of appropriate identification needed to confirm identity before signing the AOP</i>
<i>Less common issues (5-10% of respondents)</i>	
Young parents or minors	<i>Difficulty understanding the AOP process</i>
Language barriers	<i>Mother or father does not speak English and staff must access translation services</i>
Education	<i>Illiteracy or difficulty understanding language on AOP forms</i>
Child support	<i>Questions about child support and the process of opening a child support case</i>
<i>Additional issues (< 5% of respondents)</i>	
Outside interference	<i>Other family members or relatives attempts to influence or interfere in the AOP process</i>
Relationship issues	<i>Parents have a disagreement or argue during the AOP process</i>
Paternity issues	<i>Uncertainty regarding the identity of child's biological father</i>
Pressure to sign forms	<i>Father is pressured to sign forms by mother or others</i>
Undocumented parents	<i>Fear or uncertainty about providing information or signing due to citizenship status</i>

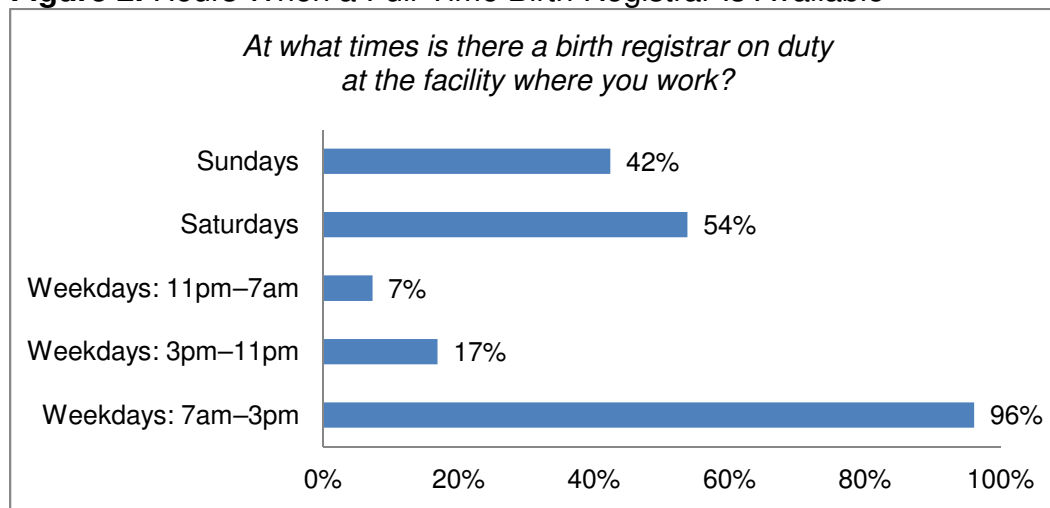
Source: NBAR Survey

Most Common Issues

In Texas, parents must sign a third-party AOP when the mother indicates that someone other than her husband, or recent ex-husband, is the biological father of the child. If the mother is currently married, both the

husband and the biological father must be involved in the AOP-signing process, with the husband signing a denial of paternity so that the father can acknowledge paternity.¹⁴ This scenario can be further complicated by the fact that a mother need not be currently married to trigger the third-party process. If she has been married within 300 days prior to the birth, she must still ask her ex-husband to deny paternity so that the biological father can acknowledge it. This legal requirement may appear arbitrary to a married mother who has had no recent contact with her husband, or to a mother who finalized her divorce before becoming pregnant but within the 300-day window prior to the birth. It may be especially unsettling for a mother whose relationship with a current or ex-husband is acrimonious or abusive. In the NBAR survey, birth registrars noted that administering the AOP process in these cases takes longer and is often difficult for parents to understand. Moreover, due to the sensitivity of the issue, it frequently gives rise to arguments among parents or between parents and hospital staff.

Another common issue is fathers' absence from the birth. Data collected from unmarried parents through the PES survey reveal that 23 percent of unmarried fathers are not present at the birth of their child, and that these fathers make up more than two-thirds of those who do not establish paternity in the hospital. A related problem noted by roughly one-quarter of birth registrars in the NBAR survey is schedule mismatch between fathers and birth registrars. Fathers might have conflicting work schedules, live far from the mother, or be incarcerated. Though hospitals work to ensure that there is always a staff member with AOP certification available to administer the AOP, that staff member may not always be a full-time birth registrar. Certified staff that is not full-time birth registrars may find it difficult to set aside their primary duties during the unpredictable or irregular hours when working fathers arrive at the hospital. Figure 2 shows the windows of time during which staff devoted primarily to birth registration (staff with the job title of "birth registrar") are on duty at the hospital. As seen in the graph, relatively few birth registrars are on site during the evenings and weekends, times during which working fathers are most likely to be available. Although other AOP-certified staff can guide parents through the paternity acknowledgment process, their relative lack of experience may negatively affect the outcome.

Figure 2. Hours When a Full-Time Birth Registrar Is Available

Source: NBAR Survey

A lack of proper identification ranked as another of the most common issues encountered by birth registrars in the NBAR survey. Staff notes that the problem of fathers forgetting or otherwise not having appropriate ID regularly complicates or lengthens the AOP process. Given the many forms of acceptable identification, it's unclear whether this problem can be attributed solely to fathers; it is possible that some birth registrars themselves are unaware of the full range of legally acceptable forms of identification.

Less Common Issues

Several of the less common, often overlapping challenges parents face relate to difficulties understanding the AOP form. These difficulties, as noted by birth registrars in the NBAR survey, include cultural differences, language barriers, low literacy or education (especially when parents are young), and confusion about legal language or implications [Table 2]. Undocumented parents are sometimes reluctant to sign or provide information due to fears about citizenship status. Parents also face interpersonal challenges; disputes can arise between a mother and father, or between parents and other family members who attempt to influence parents' choices about signing. Doubts about paternity play a role as well.

Several of these less common issues fall under the umbrella of cultural, language, and literacy barriers. Parents from a range of countries give birth in Texas hospitals. Birth registrars face both language barriers and cultural differences when explaining the process to these parents. Although the AOP form is available in both English and Spanish, birth

registrars indicate that language discrepancies persist and often make the AOP process more difficult for parents. In the NBAR survey, nearly half of birth registrars report that it is somewhat or very common for cultural differences to make it difficult for parents to understand the AOP, and a majority says that it is somewhat or very common for language barriers to make it difficult to communicate with parents about the AOP. In light of communication challenges, nearly one-quarter of birth registrars report that they rely on the toll-free number provided by the OAG to help explain the AOP to parents “more than half of the time.” Birth registrars face similar challenges communicating with minors and parents with low literacy. In fact, registrars report that these groups present the most difficulty, in part because they have trouble with the complexity of the legal language in the AOP.

Legal Language & Ramifications

A notable subset of problems encountered during the AOP process result from difficulty understanding the legal language on the form. In response to multiple NBAR survey questions, birth registrars noted that the wording and layout of the AOP commonly lead to misunderstandings, and that certain legal terms or concepts are especially likely to generate confusion for parents. Altogether, 43 percent of birth registrars felt that it was somewhat or very common for language on the form to be too difficult for parents to understand. An overview of the most commonly misunderstood sections is presented in Table 3. As might be expected, these stumbling blocks reflect many of the issues discussed above. The most problematic language is found in passages relating to child support, third-party AOPs, genetic testing, and rescissions.

Table 3. AOP Sections That Are Most Difficult for Parents to Understand

<i>Sections of the AOP that Parents Have the Most Difficulty Understanding</i>	
Section	Issues
Benefits, Rights, and Responsibilities Section	<i>Difficulty understanding issues related to child support: How/if a child support case will be opened; some think father will automatically have to pay child support after signing</i>
Denial of Paternity Section	<i>Difficulty understanding denial process and definition of “presumed father”</i>
Genetic Testing Section	<i>Difficulty understanding issues related to DNA testing; some parents mistakenly think they are signing a form to get a DNA test or will be required to get a DNA test</i>

Change of Mind Section	<i>Difficulty understanding process of rescission and related phrases, including “Rescission of Acknowledgment of Paternity” and “fraud, duress, or material mistake of fact”</i>
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Source: NBAR Survey

Difficulty understanding child support and related language in the *Benefits, Rights, and Responsibilities* section of the AOP was one of the most common issues mentioned by birth registrars. Many reported that they often receive specific questions about how or if a child support case will be opened, and in some instances, that parents mistakenly think that the father will have to pay child support if he signs the AOP form. Given the legal complexity surrounding third-party births, it is perhaps unsurprising that unmarried parents also have difficulty understanding issues related to this topic. Birth registrars note that many parents express concerns with specific language in the *Denial of Paternity* section, such as the definition of “presumed father.”

Legal language found in the *Change of Mind* and *Genetic Testing* sections are also problematic for parents. Birth registrars report that parents often have difficulty understanding the meaning of rescission and related phrases, including “Rescission of Acknowledgment of Paternity” and “fraud, duress, or material mistake of fact.” Staff field a variety of questions related to genetic testing as well, and report that some parents mistakenly think they are signing the AOP form to receive a DNA test, or will be required to take a DNA test after signing.

Parents’ difficulty understanding genetic testing is of particular importance because this issue is closely related to many areas of common concern for unmarried parents, such as child support and uncertainty regarding the identity of the child’s biological father. Birth registrars in the NBAR survey report that questions about DNA testing are common. More than 4 in 10 birth registrars estimate that they are asked about DNA testing with roughly 10 percent of the unmarried parents they serve. Thirty-five percent of birth registrars say it is even more common, and the issue comes up with approximately 20 to 30 percent of unmarried parents. More staggering still, roughly 1 in 7 birth registrars say that DNA testing is a concern with at least half of unmarried parents.

Although questions regarding genetic testing appear to be a familiar, if not pervasive issue, 4 in 10 birth registrars do not feel “very prepared” to answer these questions or address parents’ concerns about DNA testing. This lack of preparation may affect parents’ decision to establish paternity, as data from the PES survey reveal. Relative to

parents who sign the AOP, those who do not sign are significantly less likely to say that the birth registrar informed them of their ability to request a DNA test before establishing paternity. Similarly, they are less likely to feel that the birth registrar was able to answer questions about the AOP or paternity establishment.

Birth Registrars' Understanding of the Paternity Establishment Decision

Our final research question examines how well birth registrars understand the rationale and circumstances behind parents' decisions regarding paternity establishment. This line of inquiry is important because it explores potential areas of misunderstanding that could impede successful communication and ultimately affect whether or not parents sign the AOP. To determine the degree to which birth registrars understand the motivations behind parents' paternity establishment decisions, we compare answers from birth registrars and unmarried parents collected through two separate surveys. Although the data reveal some gaps in understanding, they make clear that, overall, birth registrars are largely aware of why parents choose to establish paternity or not. One notable area in which birth registrars appear to have a weak grasp of parents' circumstances, however, is in their awareness of family violence; birth registrars vastly underestimate the prevalence of family violence among parents they serve, and without relevant training, remain ill-equipped to address this complex issue.

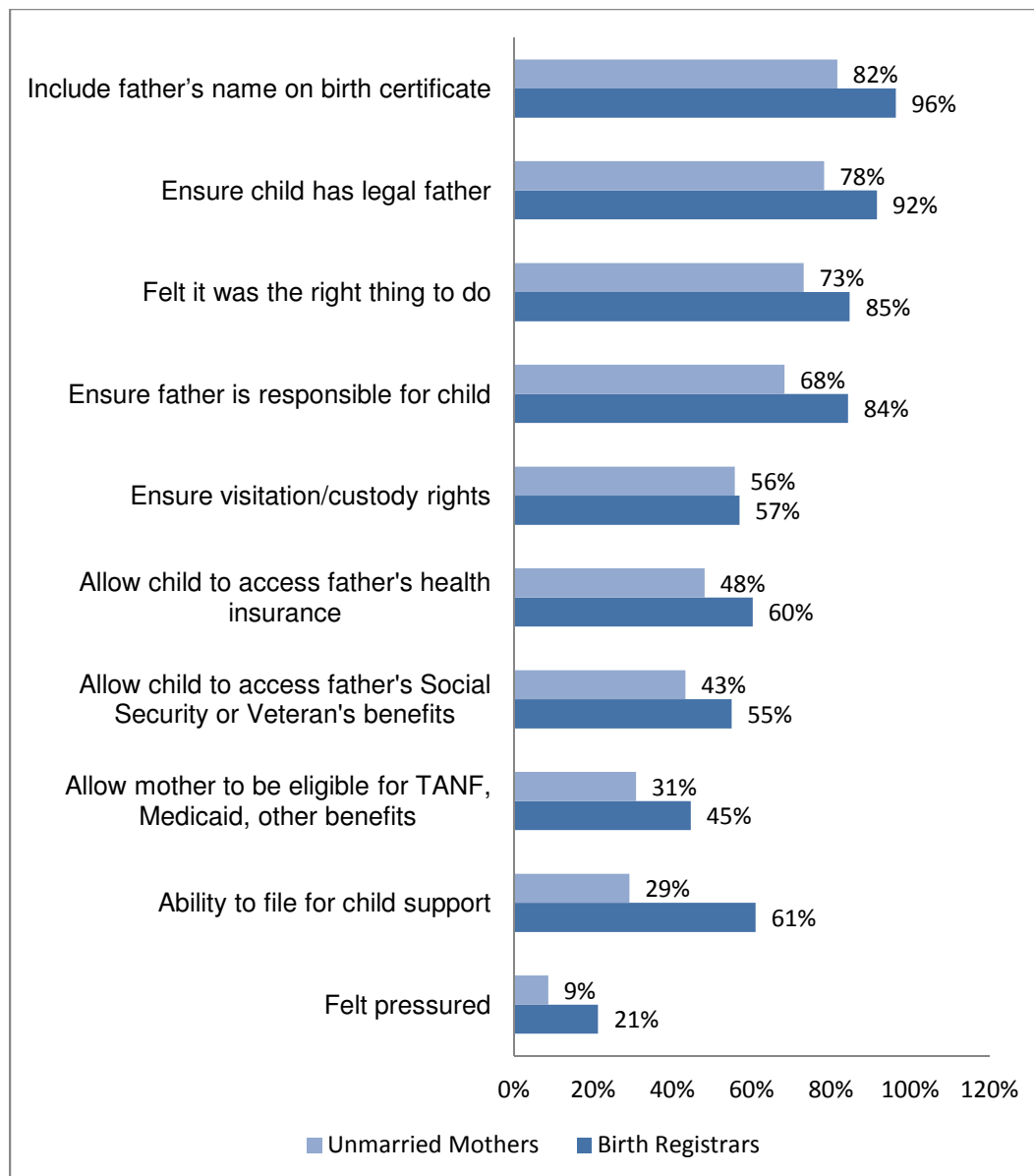
Reasons for Establishing Paternity

As shown in Figure 3, there is significant congruence between birth registrars and unmarried mothers in rank ordering the reasons for establishing paternity. Not only do mothers and birth registrars most commonly cite the same four reasons, they prioritize them in the same order as well. In both groups, the most common reason given for establishing paternity is "to have the father's name on the birth certificate," while the second most common is "to make sure the child has a legal father." This pattern holds through the fourth most common answer, a finding that suggests birth registrars are perceptive in understanding the issues foremost on parents' minds when establishing paternity. Taken together, the top four reasons for signing the AOP seem to underscore the symbolic and emotional importance of paternity establishment, rather than the instrumental or financial importance.

Prioritization differs only slightly among the remaining six reasons, with one notable exception: birth registrars are twice as likely as mothers to

feel that the ability to file for child support is a significant motivator in the decision to establish paternity. This consideration is among birth registrars' top five reasons, but it is only second-to-last among Texas mothers. The discrepancy between mothers and birth registrars on this issue is not altogether surprising. Birth registrars are certified to carry out the AOP process by the state Child Support Division, a structural arrangement which situates the AOP process within the context of child support for those who administer it. Unmarried parents are less likely to make this mental connection—especially those who sign the AOP. Results from the PES survey show the majority of AOP-signing parents have strong relationships—75 percent are living together and another 15 percent are dating; moreover, the majority of those who establish paternity in the hospital will never enter the child support system, suggesting they may be right to give this consideration reduced priority. A final factor worth considering is the oft-noted sense of optimism pervading the “magic moment” of birth, a dynamic detailed by Edin and Kefalas that may give an artificial sense of security about the relationship and obscure more somber prospects like that of child support.³³

Figure 3. Common Reasons Why Parents Sign the AOP in the Hospital



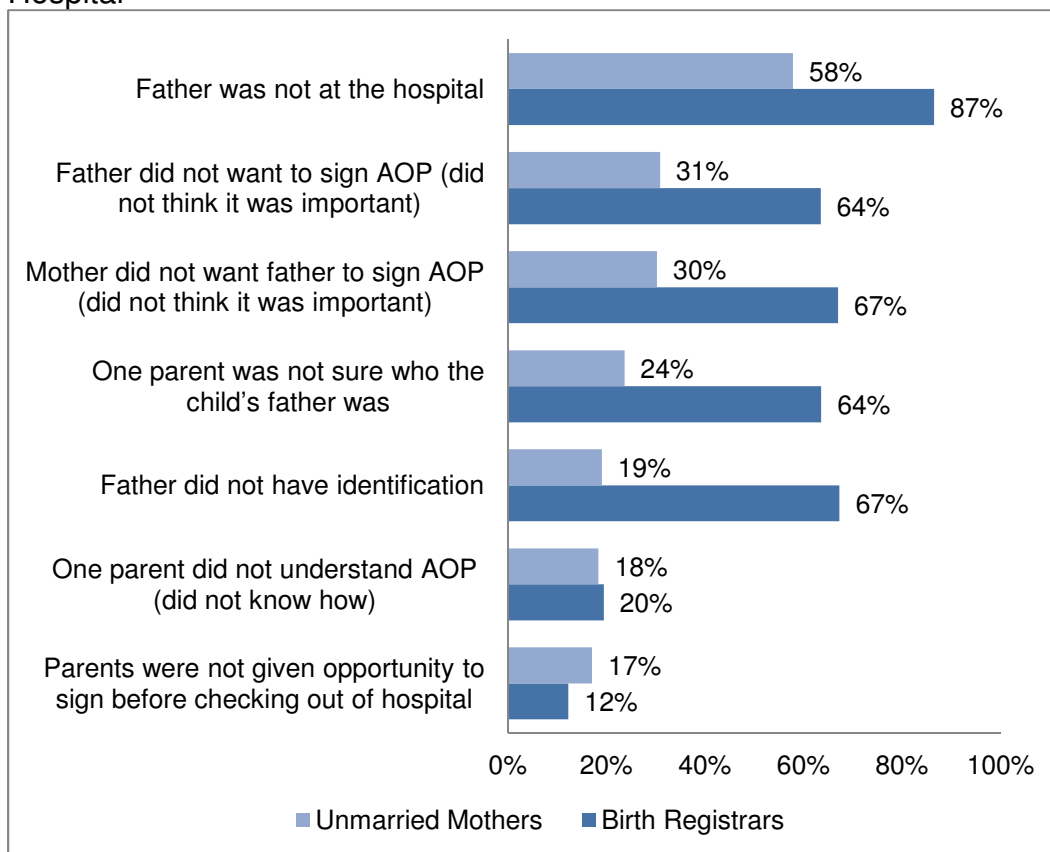
Source: NBAR Survey; PES Mothers at 3 months, weighted

Note: Percentages add to more than 100% due to respondents' ability to select more than one reason. NBAR responses are those indicating that a reason is "very common" or "somewhat common." PES survey responses are "yes" or "no."

Reasons for Not Establishing Paternity

Broadly speaking, birth registrars also appear to understand parents' reasons for declining to establish paternity (Figure 4). Because the data are derived from separate surveys, slight variations in wording and response options result in noticeable gaps between mothers and birth registrars for most answers; in considering the degree of shared perspective, these percentage differences are less important than the similarity between each group's rank ordering. The same reasons appear among the most- and least-cited for both mothers and birth registrars, with a clear majority pointing to the absence of the father as the most common reason for not establishing paternity at the hospital.

Figure 4. Common Reasons Why Parents Do Not Sign the AOP in the Hospital



Source: NBAR Survey; PES Mothers at 3 months, weighted

Note: Percentages add to more than 100% due to respondents' ability to select more than one reason. NBAR responses are those indicating that each reason is "very common" or "somewhat common." PES survey responses are "yes" or "no." Due to

alternate wording between surveys, we include PES responses in parentheses where relevant.

Some divergence among the groups is notable, however. For example, the least common reason for not establishing paternity is that the parents simply did not have the opportunity to sign. Even though mothers and birth registrars appear to agree that this issue poses less of an obstacle to paternity establishment than other issues in the survey, it is the only one cited by a larger proportion of mothers than birth registrars. This finding may suggest that birth registrars are underestimating the problem. On the other hand, it may reflect cases in which the father was absent from the birth and the mother was not offered the opportunity to complete a partial AOP. Survey data from the PES study reveal that, in cases where paternity is *not* established, the father is absent from the hospital more than two-thirds of the time. In these instances, the mother should still be offered the chance to complete a partial AOP; however, POCs revealed in the roundtable discussion that there may be confusion among birth registrars on this point, leading some to forgo the AOP process when the father is not present.

Somewhat predictably, birth registrars are also less likely to report that parents have not understood their explanation of the AOP. The proportion of birth registrars citing this reason is considerably smaller than the proportion citing other reasons, but among unmarried mothers the proportion who report having trouble understanding the AOP is roughly in line with other reasons given for non-signing. This pattern suggests that birth registrars may be out of touch with the relative magnitude of the problem: though it is among the least-cited for both groups, it is nonetheless significant that nearly 1 in 5 non-signing mothers do not understand the paternity establishment process.

Several other reasons for not establishing paternity reveal variation between unmarried mothers and birth registrars. Mothers are more likely to say that they did not sign the AOP because they did not think it was important than because the child's paternity was in doubt; however, birth registrars believe these issues to be equally common.

Awareness of Family Violence

Though the two topics may seem initially unrelated, the existence of family violence is a critical consideration in the in-hospital paternity establishment decision. Although most unmarried parents are encouraged to establish paternity in the hospital, the preferred method of paternity establishment in cases of family violence is through the court system where legal parameters can be placed on a father's visitation access to the mother

and child. Efforts to divert cases of family violence to the judicial system, however, require identifying relationships in which violence occurs—a notoriously difficult task given the relatively brief interaction between most birth registrars and parents. Even among primary care physicians, who typically have more training and a deeper familiarity with patients, under-detection of physical and emotional abuse is quite common.³⁴⁻³⁷

Though it is difficult to know the true prevalence of abuse, prior research estimates that one-third of all Texas women have experienced family violence.³⁸ Among unmarried Texas mothers with newborns, PES survey results indicate that nearly 20 percent have experienced family violence in the last year since becoming pregnant. Given the inherent challenges to detecting family violence in the hospital, however, it is perhaps not surprising that birth registrars are largely unaware of these high rates. In the NBAR survey, more than 9 in 10 birth registrars estimate that the rate of violence among families they serve is 10 percent or less—roughly half the actual rate. Moreover, even when birth registrars do detect relationship violence, they have no guidelines or training as to how it should be addressed. As a result, only 3 percent of birth registrars report ever intervening or redirecting the AOP process due to concerns about family violence. In view of the challenges surrounding detection and intervention, it is perhaps unsurprising that many abusive fathers continue to establish paternity in the hospital. Data from the PES survey reveal that, in Texas, nearly 9 in 10 abusive fathers who are present at the hospital sign the AOP. This high rate of signing is on par with nonviolent fathers, who establish paternity in similar numbers when present at the birth. PES data also show, however, that roughly half of violent fathers do not attend the birth, a trend which may account for why birth registrars tend underestimate the prevalence of violence among families they serve. More broadly, findings from the PES study suggest that fathers' absence from the birth may act as a useful signal for the likelihood of violence. When both parents are present at the hospital, family violence occurs in approximately 13 percent of cases. Among mothers who are unaccompanied by the father at the hospital however, an astounding 43 percent report family violence. This dramatic discrepancy in the rate of violence may be useful information for birth registrars attempting to understand the likelihood of abuse among different parents they work with.

Discussion

This paper provides the first overview of the in-hospital paternity establishment process since the enactment of several legislative and regulatory changes in the mid-1990s. These changes, originally intended

to simplify and promote methods of voluntary paternity establishment, have resulted in large increases in the number of unmarried parents who establish paternity, and especially the number who do so in the hospital voluntarily. In the wake of these developments, most research has focused on understanding the characteristics of parents who elect or decline to establish paternity in the hospital. We extend this research by evaluating a different angle of the in-hospital paternity establishment process using the state of Texas as a case study. To present a broad portrait of the process itself, we solicited perspectives from various groups, including unmarried parents, birth registrars, and regional Paternity Outreach Coordinators (POCs) tasked with oversight of the program. We investigated four primary questions related to the work of in-hospital paternity establishment, and in particular, pursued a deeper understanding of who birth registrars are, what their workload entails, whether they are adequately prepared and supported to execute their work, and the extent to which they are effective in working with parents.

Results from this study make clear that, in general, hospital staff who administer the in-hospital paternity establishment process perform effectively in what is often a challenging and underappreciated role. The group of staff that is certified to administer the acknowledgment of paternity process holds an array of job titles, and the majority juggle this task alongside other primary duties such as hospital management, administration, and nursing. Heavy workloads and relatively low wages are common features of the job, and most certified staff are either relatively new to the position or veterans of 10 years or more. The tendency for staff tenure to cluster at the extremes underlines an ongoing and laborious set of challenges resulting from high turnover. As a result of high turnover, regional POCs are tapped to surrender additional time and resources to in-person training, while parents are asked to make an important legal decision in the hands of staff with limited experience or legal expertise. In spite of these shortcomings, the in-hospital paternity establishment process appears to be largely successful in its primary goal. As a group, birth registrars are responsible for successfully guiding more than 70 percent of unmarried Texas parents—and an impressive 90 percent of parents who are both at the hospital—to sign the AOP.

These high rates of in-hospital paternity establishment are made more impressive by the ability of birth registrars to navigate a number of structural challenges within the hospital environment itself. Though Texas birth registrars appear to be well-supported by nursing staff, they are less likely to receive the full support of hospital management. As a matter of course, the AOP is embedded within the larger birth registration process,

and often adds considerable time, if not complexity and tension, to the practice of registering a new birth. Because hospitals are legally required to carry out this process but remain financially uncompensated for doing so, they tend to emphasize routine customer service and conflict avoidance, potentially at the expense of ensuring that parents understand what they are signing.

The widespread emphasis on perfunctory customer service goals seems to further obscure comprehension of what is already an abstruse process for many parents. Birth registrars report that parents have substantial difficulty understanding legal language in the AOP, and regularly raise questions pertaining to child support, denial of paternity, rescission, and genetic testing. This general lack of understanding is compounded by common snarls in the process itself. Birth registrars note that procedural complications are especially prone to arise from third-party AOPs, a lack of father availability, and an absence of proper identification.

Though birth registrars tend to identify the same skein of obstacles in the process, they do not always have a clear understanding of how these issues should be addressed. Individualized training sessions and a decentralized oversight program lead to regional variation in how birth registrars respond to circumstances that arise in legal grey areas. Third-party AOPs, for example, are treated differently across the state as a result of disparate legal directives passed down by regional POCs. DNA testing provides another example. Though questions around this topic appear to be relatively common, birth registrars do not always feel well-equipped to answer them.

Though birth registrars may be ill-prepared to handle some of the more nuanced legal and operational tangles that arise, they do appear to be largely in tune with parents' motivations and concerns around in-hospital paternity establishment. On the whole, birth registrars show a strong grasp of what motivates parents to sign the AOP, noting the salience of the father's name on the birth certificate and other symbolic concerns over more tangible aspects of what paternity establishment confers. Birth registrars also appear cognizant of parents' reasons for not establishing paternity, including fathers' absence from the hospital and a feeling that it is not important.

Taken together, our findings carry important policy implications for strengthening the in-hospital paternity establishment process. As the front-line staff charged with administering an often unfamiliar legal document with far-reaching consequences, birth registrars are entrusted with significant responsibility in guiding unmarried parents to make an important legal decision. In many cases, this process is simple, practical,

and effective. In some cases, however, birth registrars are confronted with issues that lie outside of their training, experience, or legal knowledge. These circumstances raise questions about whether birth registrars are the appropriate staff for handling complex and sensitive issues such as disputed paternity, third-party AOPs, or family violence. Some parents may benefit from access to an adviser with more extensive legal expertise before making the decision to establish paternity in the hospital.

More generally, efforts should be made to address deficiencies in parents' understanding of the AOP process. Increasing the availability and clarity of paternity establishment information during the prenatal period would likely help in this regard, as would additional training to ensure that birth registrars can explain the more opaque aspects of the AOP in plain language. Birth registrars may also benefit from specific training and policy directives around common complications in the process, including instances in which it is not advisable for parents to voluntarily establish paternity in the hospital. Birth registrars need clear guidelines and support around how to identify and respond to cases of family violence, and larger efforts should be made to coordinate violence identification with physicians and other medical professionals so that victims can be directed into safer, alternative routes for establishing paternity.

Policymakers could also consider developing a refined policy response to cases of uncertain paternity. Given the far-reaching consequences of establishing paternity, parents who question the identity of the child's father should not sign an AOP in the hospital without the assurance of a DNA test. National data show that roughly 3 in 10 lab-accredited paternity tests reject the target father each year, suggesting the doubts of some parents may be justified.³⁹ Offering free paternity testing to these fathers would likely facilitate more accurate paternity establishments and fewer recessions. Not only could policymakers consider making paternity testing free and readily accessible in cases of disputed paternity, but they could also consider decoupling this service from any requirement to file for child support in advance, as is currently the case in Texas and many other states. Moreover, states could consider integrating access to free, nonconditional paternity testing within birthing hospitals themselves, so that parents who are unsure of the child's paternity can initiate DNA testing at the time of the birth.

The wide variation in parents' circumstances suggests that a myopic focus on increasing the paternity establishment rate may be an oversimplified and poorly articulated policy goal. Policymakers should instead turn their attention toward more nuanced measures of success, including explicit procedures for addressing situations in which the

successful outcome is routing parents into alternate proceedings that can attend to more unique circumstances. A more universal objective should be to cultivate an AOP process that ensures parents fully understand the meaning and implications of establishing paternity.

Limitations

One notable limitation of this study is the lack of input from fathers. Because too few unmarried fathers completed the PES survey to constitute a representative sample, our results draw solely on mother-reported survey data and may not always accurately reflect fathers' point of view. This shortcoming is especially evident with regard to parents' reasons for establishing or not establishing paternity, and may result in imprecise estimates of more sensitive measures, such as the prevalence of fathers who doubt paternity. Feedback from fathers is essential to a deeper understanding of in-hospital paternity establishment, and future research should make a stronger effort to ensure their perspectives are reflected in the findings.

Our work would also benefit from a more disaggregated analysis of AOP-certified staff. Though staff with the title of 'birth registrar' administer the AOP as one of their primary job duties, a somewhat larger contingent complete this process only rarely. Because this study sought to give a broad overview of the AOP process, these groups were largely treated as one in an effort to capture the full range of staff experiences and perspectives. Future research on in-hospital paternity establishment may achieve a more nuanced understanding of the process through an explicit examination of the differences between these groups, especially in view of their differing levels of experience with, and impact on, the process. Further, it should be noted that our sample of AOP-certified staff may not be representative of all staff who register births in the state. Although our data include a majority of Texas birth registrars, the response rate is too low for our results to be considered generalizable.

Finally, despite Texas' size and diversity, findings generated from this population might not be generalizable to all areas of the United States. Administrative approaches to oversight of paternity acknowledgment vary from state to state, as do demographic trends. The large Hispanic population in Texas, for example, does not accurately reflect the demographic makeup of all states. Replication of our work in states with different cultural and demographic compositions, as well as those with alternate systems of oversight, would lend additional perspective and depth to findings outlined here.

Conclusion

Over the last few decades, the process of establishing paternity for children born outside of marriage has been simplified and expanded dramatically. As more unmarried parents elect to complete this legal process in the hospital at the time of the child's birth, understanding whether the process itself is functioning effectively for parents, hospitals, and state agencies becomes increasingly important. Overall, our findings indicate that despite heavy workloads, high turnover, relatively low wages, and varying levels of support, birth registrars are largely effective in their execution of the in-hospital paternity establishment process. In the face of what can be a complex, emotionally charged, and even contentious subject, birth registrars guide a remarkable 90 percent of unmarried parents who are both at the hospital to sign the AOP. Because hospitals receive no funding for the paternity establishment services they are legally required to provide, their goals—largely oriented toward customer service—often prioritize expediency over concerns about parents' comprehension of the legal issues at stake. To birth registrars' credit, our data show that they nonetheless remain largely in tune with the concerns of parents they serve.

Despite these successes, our findings make clear that birth registrars confront a range of issues that lie outside of their training, experience, and legal knowledge. In particular, they lack clear and consistent protocols for dealing with third-party births, partial AOPs, family violence, and questions about DNA testing. Issues that arise in these areas are sometimes further exacerbated by inconsistent counsel from regional oversight staff. Our findings also identify logistical challenges that consistently complicate the process, including difficulties with legal language and scheduling mismatch between birth registrars and fathers.

We urge further research into the achievements and shortcomings of this widely used legal process that, despite far-reaching implications for children and families, has gone largely unscrutinized in recent decades. While the convenient and streamlined system has resulted in dramatic increases in the rate of voluntary paternity establishment, it achieves this success at the price of more nuanced policy goals, such as the ability to effectively navigate complex or unique circumstances. Our work would benefit from similar investigation in other states, as well as more refined analyses around issues of genetic testing and family violence.

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