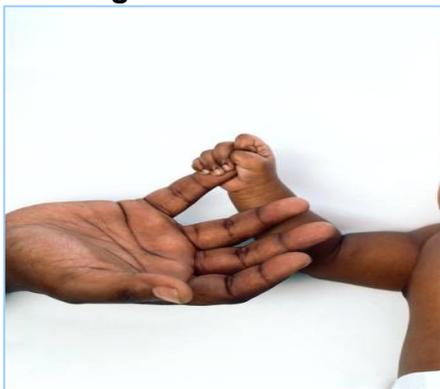


cies of grandparent headed families, any intervention by social services should be holistic in nature, addressing the needs of both the grandchildren and the grandparents. It is critical that grandparents are supported in their role as this custody arrangement is almost always the most ideal if the birthparents are not able to provide a secure and stable environment.

Though most discussions about grandparents raising grandchildren dwell on the challenges, the stories of these families are remarkable. I continue to be amazed at the grandparents who step forward to provide a safe harbor for the children. However, their need for support cannot be overstated because, after all, even the lighthouse has a keeper.

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Outreaching to Expectant And New Parents about Paternity and Child Support: Opportunities and Challenges



Introduction

With nearly 40 percent (39.7%) of all births occurring to unwed parents, and unmarried parents making up over half of the child support caseload nationally (Pontisso, 2009), it is more important than ever for child support agencies to reach unmarried parents around the time of the birth of their babies to communicate important messages about paternity and child support. The [Fragile Families and Child Wellbeing Study](#) shows that one year after birth, only 58 percent of unmarried parents were still romantically connected, only 9 percent were married, and only 12 percent had a legal child support order (McLanahan and Garfinkel, 2002). The short amount of time that most parents spend at a hospital or birthing center makes it hard to capitalize on the “magic moment” of birth for effective education and outreach. Nor does the traditional model of prenatal care consisting of brief, one-on-one visits with a provider lend itself to an educational intervention.

“Through 1115 and SIP (Special Improvement Project) grants, OCSE has supported new approaches to reach unmarried expectant, and new parents and educate them about paternity and child support.”

One project conducted in Austin and

Dallas, Texas, The New Parent Outreach Project, used hospital staff to conduct one-on-one educational counseling about parenting rights and responsibilities, paternity, and child support within a few days of the birth of a baby. The challenges were formidable. At one hospital site, the program was dropped because of unexpected loss of staff and competing, time-consuming commitments to a transition to an electronic health record system. At a second hospital site, the project was hampered by human subject protocols and lack of staff availability due to scheduling difficulties, changes in staff role assignments, and resource allocation. The evaluators concluded that it was not feasible to conduct outreach with existing hospital human resources and that any expanded efforts to reach parents at the hospital with a broader parenting and paternity message would require resources and staff from additional community or government partners (Lein et al, 2008).

This article describes grant-funded efforts to conduct outreach with expectant and new parents in two settings that afford more time and patient access than hospitals, and are more oriented to educational interventions: “CenteringPregnancy” programs and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) nutrition classes.

Outreach Through “CenteringPregnancy” Programs

CenteringPregnancy replaces conventional, individual, prenatal care with a group-centered model that integrates health assessment, education, and support into a cohesive unit (Rising, 1998; and Rising, Kennedy and Klima, 2004). Developed more than a decade ago, CenteringPregnancy is currently offered at more than 300 sites in the U.S. and Canada. Enrollment varies at each site but a conservative estimate of 50 women per year at each of the esti-

mated 300 sites in the U.S. and Canada would lead to an estimate of approximately 15,000 patients per year.

CenteringPregnancy groups include low-risk pregnant women with similar delivery dates who enter the program at the beginning of their second trimesters. The format integrates prenatal medical checks with group support and a formal curriculum dealing with pregnancy and birth that is delivered in 10 or 12 sessions spaced several weeks apart. The groups are facilitated by Certified Nurse Midwives (CNM) or nurse practitioners and co-facilitated by clinicians or others who are trained in group process and use formal, interactive curricula dealing with pregnancy and birth. CenteringPregnancy provides opportunities for peer support, cohesion, and sustained education without the limitations of time and competing interests endemic to hospitals and birthing centers (Klima, 2003). Research shows that babies born to CenteringPregnancy participants have higher birth weights and are less apt to be born prematurely than their counterparts who receive individual care (Ickovics *et al.*, 2003) while teen participants in CenteringPregnancy have a lower no-show rate for prenatal care sessions and are more apt to return for a postpartum visit and follow-up care. (Grady and Bloom, 2004).

- As part of Strong Start – Stable Families, a project funded by OCSE under a Section 1115 research and demonstration grant to the Texas Office of the Attorney General (OAG), the Teen Health Clinics of Baylor College of Medicine in Harris County, Texas developed a CenteringPregnancy program and offered pregnant adolescents and their partners the opportunity to receive prenatal care through that program. To the regular CenteringPregnancy curriculum, Teen Clinic staff added material on paternity, child support, and healthy relationships drawn from

both the OAG curriculum Parenting and Paternity Awareness (p.a.p.a.) and OCSE resources, Parenting Two-gether, Maps for New Dads, and The Power of Two, that teaches adolescents about the rights and responsibilities of parenting, paternity establishment, and healthy relationships. At the conclusion of the three year project, 211 pregnant adolescents and 126 male partners attended group classes on pregnancy and childbirth and were exposed to material on paternity, child support, and relationships (Pearson and Davis, 2009).

- As part of Healthy Babies—Healthy Relationships, a project funded by OCSE under a SIP grant to the Center for Policy Research, CenteringPregnancy programs at the Teen Pregnancy Center at Barnes Jewish Hospital in St. Louis and Peak Vista Community Health Center in Colorado Springs, added material on paternity and child support to the regular CenteringPregnancy curriculum. Using interactive formats consistent with the rest of the CenteringPregnancy curriculum, adolescents (in St. Louis) and women of all ages (in Colorado Springs) were exposed to material about the difference between biological and legal parentage, the voluntary acknowledgment process, the benefits of paternity establishment, and fact and fiction about the child support system. The material was drawn from the Texas OAG curriculum, No Kidding—Understanding Paternity and Child Support. Currently, across the St. Louis and Colorado Springs sites, 512 pregnant women and 107 male partners have attended group classes on pregnancy and childbirth and have been exposed to material on paternity, child support, and relationships.

Collaborating with CenteringPregnancy Programs offers many opportunities and challenges for child support. As a prenatal program that qualifies for Medicaid reimbursement, it is largely utilized by low-income women—the precise population that child support seeks to reach. Its multi-session, educational format led by trusted health professionals with peer group reinforcement makes it an excellent educational setting. Although the standard curriculum focuses on the obvious issues of pregnancy, childbirth, nutrition and infant care, it also covers issues pertaining to abuse, contraception, communication with partners and social supports, which are viewed as compatible with discussions about paternity and child support. Once staff realizes that the material does not deter patients from obtaining prenatal care and offers information that can help their financial circumstances, they are supportive of the curriculum enhancement. Finally, expectant parents in CenteringPregnancy programs who are exposed to information on paternity and child support rate it favorably. Although few new parents report that they want court-ordered child support, most say that it is very helpful to learn about the legal and financial side of parenting and to better understand their rights and responsibilities.

The many benefits to working with CenteringPregnancy are offset by a variety of challenges. One challenge is finding enough time in the ambitious CenteringPregnancy curriculum to add material on paternity and child support. The standard 10-session program is packed with learner objectives. In addition, many other programs would like to incorporate their messages in the sessions. Child support faces stiff competition for program time. Another challenge is to present material on paternity and child support in an interactive, participatory manner and avoid didactic approaches that conflict with the program's philosophy. The materials developed by the Texas OAG are

great resources, but it remains challenging to present legal information in an engaging, interactive manner. Male participation in CenteringPregnancy groups is low, even in programs such as those in St. Louis and Colorado Springs, where fathers are welcome. Training health care facilitators on paternity and child support issues so that they understand the importance of the topic for their clients and feel comfortable leading sessions and/or answering questions is still another challenge. Since their major goal is providing prenatal care, health care professionals are reluctant to discuss legal issues that might frighten patients and drive them away, especially undocumented and immigrant populations.

Finally, despite its growth, CenteringPregnancy remains a relatively small program that is not routinely available in most traditional medical settings. It is locally administered which means that collaborations and program access must be developed at the local level.

Outreach Through WIC Nutrition Classes

Established in 1974, WIC attempts to increase the nutrition levels and general well-being of children. The U.S. Department of Agriculture provides states with federal grants that comprise 62 percent of the program's budget with state contributions comprising the other 38 percent. The money is used for supplemental foods, referrals to health care and social services providers, and nutrition education. The program targets low income, pregnant, and postpartum women, infants, and children up to the age of five years who are at nutritional risk and have a household income that is at or below 185% of the poverty level. Administered by 90 WIC state agencies in 10,000 clinic sites throughout the nation, WIC serves over nine million women and children. Half of WIC participants are children ages one to five; 26 percent are infants under age one; and 25

percent are pregnant, postpartum, and breastfeeding women (Children's HealthWatch, 2009). According to recent reports, WIC serves 45 percent of all infants born in the United States (Devaney, 2003).

WIC participants receive monthly vouchers to purchase foods high in the essential nutrients that are often lacking in the diets of low-income families including infant formula and cereal. In response to a recommendation by the Institute of Medicine, WIC food packages were amended in 2009 to include more fruits and vegetables. WIC's public health workers screen all immunization records of infants and children under age two and provide referrals to immunization services. WIC also conducts regular nutrition education sessions that focus on healthy eating. WIC participants are required to attend two nutrition education sessions in each six month certification period although they cannot be denied food coupons for failure to attend. (Children's HealthWatch, 2009).

Research on the effects of WIC participation on children finds that the program's promotion of supplementation during pregnancy is linked to more positive birth outcomes. Indeed, a 2002 study that controlled for biases that may have been introduced by program selection and participation factors revealed a significant positive association between WIC participation and birth weight (Kowalski-Jones and Duncan, 2002). Several studies have found that prenatal WIC participants were more likely than non-participants to initiate prenatal care earlier and to receive adequate levels of prenatal care and are less likely to receive no care or care in the third trimester. Low-income children enrolled in WIC are linked to the health-care system and are much more likely to be receiving preventive and curative care (Devaney, 2003). Children under the age of three who receive WIC are more likely to be in excellent or good health than eligible children who do

not receive WIC due to access problems as well as being within developmentally normal limits and in food secure households (Children's HealthWatch, 2009).

As part of Healthy Babies—Healthy Relationships, a project funded by OCSE under a SIP grant to the Center for Policy Research, a WIC clinic operated by Roseland Hospital at Catholic Charities in Chicago, Illinois, agreed to incorporate material on paternity and child support in its nutrition classes for pregnant women and mothers of infants and children under the age of one. The material on paternity and child support is presented by project personnel who have been trained on paternity and child support. They use activities and visual aids adapted from materials developed by the Texas OAG (No Kidding—Understanding Paternity and Child Support). The 45-60 minute interactive session deals with the difference between biological and legal parentage, the voluntary acknowledgment process, the benefits of paternity establishment, and facts and fictions about the child support system. In the six months since project staff began presenting material on paternity and child support to WIC classes on a routine basis, more than 500 women and 69 men have attended the sessions. Preliminary feedback has been very positive with participants rating the information as extremely helpful and relevant to their situation.

Like CenteringPregnancy, child support collaboration with WIC has the potential to reach low-income expecting and new parents in a trusted setting that has a commitment to education. Although the program focuses on nutrition and food supplementation, one of its core objectives is to provide referrals for health care and social services, the latter of which might be construed to cover child support agencies. A further connection between USDA, the agency that administers the WIC program and the child support en-

forcement program, is the fact that the USDA prepares estimates of annual expenditures on children from birth through age 17 that is widely used by states in setting their mandated child support guidelines.

Finally, both WIC and the child support program enjoy strong cost-benefit ratings. A recent study of WIC by the U.S. Government Accounting Office found that every \$1.00 spent on WIC resulted in savings of between \$1.77 and \$3.13 in health care costs in the first 60 days after an infant's birth. Like the child support enforcement program, the program has the highest rating possible from the U.S. Office of Management and Budget's Program Assessment Rating Tool (Children's HealthWatch, 2009).

The barriers to presenting child support to target audience at WIC sites include the local nature of program administration; competition from other groups and causes who seek to present their message to the same populations; the general absence of expectant and new fathers at most WIC nutrition classes; the need to train staff to understand the importance of paternity and child support issues for their caseload; and the short amount of time normally allotted to nutrition classes. At many sites, the WIC classes have become somewhat pro forma and clients have come to expect that they can drop into the WIC site to process their recertifications and obtain their coupons and food supplements without having to do more than look at a five or ten minute video about nutrition. Finally, although the program serves 9 million, it is estimated that only 57 percent of eligible participants have actually enrolled in the program (Children's HealthWatch, 2009).



Discussion

If the child support enforcement program wants to reach expectant and new, unmarried parents about paternity and child support in settings that are less hectic and rushed than a hospital or birthing center, it will have to collaborate with a variety of programs that offer prenatal and post-partum services. All present a variety of challenges to gaining access to parents and obtaining enough time to communicate with them.

- **Access:** Collaborating with locally administered programs means that access must be negotiated on a program-by-program basis. There are an estimated 300 CenteringPregnancy sites and 10,000 WIC clinic sites.
- **Curriculum Time:** All programs have other content priorities and get many requests from other worthwhile causes to incorporate their material. There is only so much that can be added (and covered) in programs.
- **Competing Priorities:** Prenatal programs aim to provide prenatal care and are reluctant to raise legal or governmental issues that might frighten immigrant populations and discourage them from attending care appointments. WIC programs focus on nutritional improvement among at-risk mothers and their babies. As part of the

process of gaining access, child support programs would need to address these reservations and convince program administrators that the paternity/child support message is compatible.

- **Staff Training:** Staff in collaborating programs will need to be trained on paternity and child support before they feel comfortable and competent raising these issues or even having outsiders present about them. Program staff does not like getting questions from clients that they are unable to answer. Getting staff trained to deliver the material on paternity and child support themselves presents an even bigger training challenge.
- **Lack of Curricula:** With the exception of the Texas OAG, which has developed the No Kidding and the p.a.p.a. (Parenting and Paternity Awareness) curricula that teach about the rights and responsibilities of parenting, paternity establishment and the child support system in a standardized but interactive and engaging manner, there is no "off-the-shelf" module on paternity and child support that might be incorporated into a variety of prenatal, nutrition, or marriage programs across the country. Since many of these programs are interactive and process-oriented, the new curriculum would need to embed information in a more active format and have appropriate activities and discussion topics.
- **Demands on the Child Support Agency:** While some programs will prefer to use their own facilitators to deliver the material on paternity and child support, others will want outside presenters. Doing outreach at multiple sites with small audiences would place big demands on the child support agency at a time when

staffing is tight and there are competing demands for their time that are more directly related to agency performance.

- **Limited Ability to Reach Men:** While some men participate in prenatal programs and attend WIC clinics, most do not and the audience for these programs tends to be heavily female. Reaching young men about paternity and child support remains a challenge. The possible avenues for doing this include outreach through high schools (see the article on Parentage and Paternity by p.a.p.a. staffers, *Child Support Quarterly*, 2009) workforce programs and resource rooms at One-Stop Employment Centers, the military branches and academies, community and four year colleges, healthy relationship and marriage programs that cater to unwed parents, and the media.

Conclusions

As the rate of out-of-wedlock births rise, and the child support caseload becomes increasingly composed of parents who were never married, the need to reach and communicate with them about paternity and child support becomes all the more compelling.

Reaching expecting and new unwed parents and conducting an educational intervention, however, is no simple task. Like the evaluation of the Texas New Parent Outreach Project (Lein et al, 2008), this article highlights the complexity of providing outreach in suitable settings with existing staffing resources. Previous major inroads on hospital-based paternity establishment were ultimately due to federal legislation that put pressure on states to make voluntary acknowledgment programs available on a more routine and expanded basis. In a similar fashion, it took legislation (HB 2176, 2007) to get p.a.p.a. to be offered to all high school students in Texas. Getting WIC clinics to disseminate information about paternity and child support to interested clients may well take a federal mandate.

The precursors to large-scale adoption of education programs on paternity and child support, however, are developing a good educational product and forging collaborative relationships with entities that can deliver it. As the architects of the Texas p.a.p.a. project observed, "Collaboration with the education community-from bottom to top-played a huge part in p.a.p.a.'s success and will continue to impact our progress" (p.a.p.a. staffers, 2009). The OCSE demonstration projects are first steps in forging these needed collaborations.

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