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ORIGINAL PAPER

Who Calls the National Safe Haven Alliance Hotline? Evaluating One Element of Policy Implementation

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Abstract

Safe haven laws allow one to safely and legally relinquish an infant at a designated location. In this paper, we examine one key policy implementer of safe haven laws, calls to a national hotline. Using 2018–2019 call data from the National Safe Haven Alliance hotline, we present information about the callers, why they call, what actions are taken, and the outcomes. Of the 388 callers and 453 reasons that they called, we found that 56.5% wanted general information about safe havens, 13.7% want information about adoption, and 9.3% want instructions on how to relinquish an infant. Callers are connected to other resources 69.2% of the time and 18.1% are given instructions on how to relinquish an infant. Helpline staff are expected to have a broad array of knowledge regarding pregnancy, parenting, and other options. Findings are compared with research on other crisis hotlines. The discussion includes considerations for policy practice.

Keywords Safe haven · Safe haven laws · Infant abandonment

In the 1990s, infant abandonment started to receive increasing levels of attention from the media, as well as the criminal justice, child welfare, and public health professions. There is no organized, national response to infant abandonment. Thus, in response to a perceived increase in abandonments, every state in the country passed their own safe haven law (SHL), which allows parents to safely and legally relinquish an infant in designated locations, such as police/fire stations, emergency rooms, or with emergency medical personnel (Appell, 2002a, b). In the process of doing so, parents are free of charges of criminal neglect. Despite the widespread

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passage of SHLs, there is little research about the implementation and use of SHLs (Douglas, 2016; Pruitt, 2008). In this paper, we report on one element of implementation, by offering the first evaluation of call data to a national helpline focusing on SHLs, run by the National Safe Haven Alliance (NSHA). This paper will report on who calls the helpline, the reasons for their calls, the actions taken by the staff, the outcomes of the calls, and implications for policy practice.

Infant Abandonment and Relinquishment: Definition and Prevalence

Infant abandonment and relinquishment pertain to knowingly and willingly leaving behind or giving up a very young child, generally under the age of one. According to official definitions, *boarder babies* or *abandoned babies* are left in hospitals after birth, often by mothers struggling with addiction. *Discarded babies* are left in alleys, trashcans, dumpsters, church steps, or another public place without adequate care or protection (Pruitt, 2008; U.S. Department of Health & Human Services, 1998). These infants may survive, others may die. We use the terms "abandon" and "discard" interchangeably to discuss infants who are left in public places without care and protection. Infant relinquishment, on the other hand, describes a process whereby a parent leaves an infant at a designated location with approved providers or "receivers" (Wisconsin Department of Children & Families, n.d.).

The prevalence rate of infant abandonment is largely unknown. The USA does not have an official method for counting or recording abandoned or relinquished infants (Bradley, 2003; Oberman, 2008). The same is true for most states as well (Douglas, 2016). There were two studies commissioned by the US Department of Health and Human Services to assess the incidence of abandoned infants, but they are now more than 20 years old (U.S. Department of Health & Human Services, 1994, 1998). The studies took accounts from news stories using the LexisNexis database and found 65 discarded infants in 1992 and 105 in 1997. This research paved the way for SHLs, which allow for the safe relinquishment of infants at designated locations.

The most thorough study on infant abandonment was conducted in North Carolina using records from the medical examiner's office of 34 infants who were abandoned and deceased when they were discovered between 1985 and 2000 (Herman-Giddens et al., 2003). A second study was conducted in Texas, also using newspaper accounts, of 93 live and deceased infants abandoned between 1996 and 2006 (Pruitt, 2008). This research shows that discarded infants die from a variety of causes, including asphyxiation/strangulation, drowning, hypothermia/exposure, prematurity/lack of care, stabbing, blunt trauma, and heart defects (Herman-Giddens et al., 2003).

Risk Factors for Infant Abandonment

The research from North Carolina and Texas document that these states have racially and ethnically diverse populations, and this diversity was reflected among the infants who were abandoned (Herman-Giddens et al., 2003; Pruitt, 2008). Research

in Illinois shows that infants who are discarded, as opposed to being legally relinquished, are more likely to be black, indigenous, or people of color (Save Abandoned Babies Foundation, 2018), indicating a fairly substantial disparity. There is also some evidence that males may be slightly more likely to be abandoned than females (Herman-Giddens et al., 2003; Pruitt, 2008). It has been recorded that one-quarter of parents who have chosen to give up their newborn are between the ages of 25 and 41 (Save Abandoned Babies Foundation, 2018). The research in this field is very limited and there is a need to better understand the sociodemographic information and needs of parents who are in a position to abandon or relinquish an infant (Bradley, 2003).

Infants are generally abandoned by parents who are in duress or who lack the ability or resources to care for them (Bradley, 2003). Some teenage girls or women describe not realizing that they are pregnant. The labor comes unexpectedly and the resulting infant is a surprise (Tighe & Lalor, 2016a, b). In other instances, women keep the pregnancy a secret from family and friends (Meyer et al., 2006). Coming from a family or culture that does not believe in the use of contraceptives can also be related to infant abandonment (Kaplan, 2014). Previous research shows that women who abandon infants are likely to be socially isolated or to fear anger from family members or the father of the baby (McKee, 2006; Meyer et al., 2001).

Legislative Action: Safe Haven Laws

The first legislative action taken to address abandoned infants in the USA was the Federal Abandoned Infants Assistance Act, which passed in the US Congress in 1988. This law primarily targets the medical care and family needs of infants abandoned in hospitals and there is also a heavy emphasis on HIV or drug-affected infants ("Abandoned Infants Assistance Act," 1988). The rise of laws in the USA that allow parents to relinquish an infant started in 1998, Mobile, Alabama with a local initiative (Carter, 2013; *Recognizing Mobile County District Attorney John Tyson and his work in creating the Alabama Secret Safe Place program*, 2008). Not long after this, Texas passed the nation's first SHL in 1999 (Jaccard, 2014; Tebo, 2001). The law allowed parents of infants up to 60 days old to relinquish their children at a hospital, with emergency medical staff, or at a welfare office without suffering criminal prosecution (Tebo, 2001). Within a decade, all of the states in the nation, including Washington, D.C., had adopted their own SHLs ("D.C. Council OKs newborn safe haven," 2009; Domash et al., 2010; Jaccard, 2014).

SHLs permit parents to safely relinquish an infant at a designated place where the infant will be protected and then turned over to child protective services (Appell, 2002a). To safely relinquish an infant means to leave an infant up to a designated area at a location that is determined by state statute, in the care of a professional or other designated individual. The infant must be free from signs of abuse or neglect at the time of relinquishment. This action prompts the termination of parental rights to the child and also protects parents from criminal prosecution of child abandonment. On average, states designate three or four locations where an infant can be

safely relinquished. Most often, infants can be relinquished at hospitals, fire stations, and police departments (Douglas & Mohn, 2014). Most states stipulate that an infant can be relinquished between "up to 72 h" old and 1 month old. Despite the fact that SHLs have existed for 10 to 20 years, there has been very little research on the implementation of the policy, such as how members of the public or professionals who might receive an infant learn about the laws, the questions that they have about them, and what happens when someone wants to relinquish an infant. A national hotline has played an important role in the dissemination of information about helplines.

Hotlines as Policy Implementers

Since their inception in the 1950s, crisis hotlines or helplines—the terms are used interchangeably—have been providing emotional and support services to those in immediate need and who reach out (Middleton et al., 2016). There are numerous helplines nationwide that vary with which population they serve. Helplines provide both general and immediate support and interventions for those who call and are usually available 24 h a day, 7 days a week. These hotlines are staffed by both volunteer and paid employees with varied degrees of training and education (Kalafat et al., 2007).

Hotlines play an important role as implementers of some social and health-related public policies, especially those that address individuals in crisis. One example of this is mental health or suicide crisis lines. They are a key element of implementing suicide prevention legislation (Substance Abuse Mental Health Services Administration, 2020). Suicide hotlines provide the easiest and most direct access for someone to receive life-saving care. Research has shown that those who utilize helplines have poor physical health, mental health, and have a lack of social support in their lives (Kalafat et al., 2007; Spittal et al., 2015). Middleton et al. (2016) examined reasons why people may call a helpline frequently and determined that those who call are, most generally, looking for someone to talk to and assist with mental health symptoms. Callers are seeking help to meet their immediate and short-term needs. Similarly, the NSHA hotline provides immediate access for those in crisis who need to relinquish an infant.

National Safe Haven Alliance Hotline

NSHA is a nonprofit organization that originated in 2004. It provides oversight and support to all states and territories with regard to infant relinquishment and parenting resources. To date, NSHA has helped more than 4000 mothers with a SH relinquishment (National Safe Haven Alliance, n.d.-b). The mission of NSHA is to support "parents facing unplanned pregnancies with safe alternatives that prevent infant abandonment while providing holistic care for both parents and babies" (National Safe Haven Alliance, n.d-b., paragraph 1). NSHA also hosts a 24/7 crisis helpline and uses a three-tiered approach to working with callers on three options: (1) parenting, (2) adoption,

and (3) SH (National Safe Haven Alliance, n.d.-a). The hotline is operated by two organizations, Option Line (https://optionline.org/) and NSHA. Option Line is a pregnancy support resource center, which also provides a hotline to those with pregnancy-related concerns. Option Line handles all incoming calls for the NSHA helpline. If they receive calls that are beyond the capacity of the Option Line staff, the call is transferred to NSHA staff. All calls are logged and recorded as NSHA calls.

Current Paper

The purpose of this paper is to begin to fill some of the gaps in our knowledge about help-seeking concerning infant abandonment and infant relinquishment. This is done through the use of the NSHA hotline data. The information from these calls are used in this paper to address the following research questions.

1. What are the characteristics of callers and how did they learn about the hotline?
2. What are the reasons that someone calls a SH hotline?
3. What are the actions taken by the hotline staff to help the callers? What are the outcomes of the calls? And, how do the actions and outcomes vary by the reasons for calls?

Methods

Data

The data for this study comes from the case records of the NSHA hotline. NSHA first started recording information about calls to the hotline in 2018. This paper presents data from 2018 and 2019, which, as of the writing of this paper, are the only years that the data is available for examination. The data was recorded by volunteer and paid hotline staff. A total of 588 calls were made to the NSHA helpline in 2018–2019. Individuals sometimes called for multiple reasons; thus, we coded the data for every reason that a call was made. In total, we recorded that there were 692 reasons that someone called a helpline. In 200 of those reasons, "No information, not enough information to determine reason for call, hang up, wrong number, or prank" was listed as the sole reason that someone called the helpline. These individuals were removed from the data. Additionally, 13 individuals were coded as "No info, hang up, wrong number, or prank," but since they had other reasons for calling the helpline, these cases remain in the sample. The final sample is comprised of 388 callers and 453 reasons for calling.

Procedure

The hotline data was provided to the first author (EMD) in Excel spreadsheets, first at the end of 2018 and then at the end of 2019. The first author and third author, an undergraduate research assistant (LST), worked together to develop a coding scheme for the

data and this was applied to the 2018 data. One year later, when the 2019 data were available, they were combined with the 2018 data. A second undergraduate research assistant joined our team and in order to maximize accuracy and precision, all of the coding categories were reviewed and revised to reflect the 2 years' worth of data. All of the data was coded again. The data did come to us with some basic coding from both the Option Line and NSHA which we retained, but most of the coding was completed by our team.

The students worked in parallel, coding a pre-designated number of cases each week and then meeting to compare the codes that were made. Cases where codes did not match were discussed and resolved together between the two students. When the codes could not be reconciled, the first author resolved the discrepancy. Of the 586 cases/calls that were coded, the students' inter-rater reliability was 72.3%. They were able to come to a resolution on their own with regard to the coding 80.2% of the time. The rest of the time, 19.8%, the first author resolved the discrepancy. The students improved their coding and rate of reliability over time. Once they were half way through the cases, their inter-rater reliability was 83.1% and their ability to resolve differences increased to 87.8%.

Measures and Data Analysis

Table 1 shows what information the helpline collected and how we transformed that information into variables for use in data analysis. In summary, we provide information about how callers learned about the helpline, whether they are pregnant or calling about a pregnancy, if they are calling about themselves or someone else, their reasons for calling, the actions taken by the staff, and the outcomes of the call. We used descriptive, univariate, and bivariate analyses to examine the data. There was significant missing data among the outcomes of the calls. We used descriptive, univariate analyses, and, thus, did not use statistical methods to correct for this.

Results

Characteristics of Callers?

Table 2 displays the characteristics of callers who contacted the NSHA Helpline. The information that is collected about participants is limited to how they learned about the helpline, if they are calling about themselves or someone else, and if they are pregnant or calling about someone who is pregnant. The vast majority of callers (66.46%) learned about the helpline through the Internet. Almost three-quarters (72.2%) called the helpline about themselves and only 12.9% called the helpline about a pregnancy—either theirs or someone else's.

Table 1 Information collected from Safe Haven Helpline

Helpline information	Coding responses
How caller learned about helpline	Another hotline Brochure Crisis pregnancy center Friend/word of mouth Internet Previous contact Radio School Social services Other
Reason for call	Adoption info Business call Education info/resources Pregnancy-related Safe haven relinquishment: general info Safe haven relinquishment: instructions Seeking help, not safe haven-related Other
Caller is pregnant or calling about someone pregnant	Yes No Unknown
Caller identity	Self Someone else
Action the helpline staff took	Instructions on how to relinquish infant Referral to adoption agency Referral to internal contact/NSHA network Referral to local child protection agency Referral to outside agency Follow-up Other
Outcome of call/staff assistance	Adoption Keep child SH relinquishment

Why Does Someone Call a Helpline?

Table 3 shows the reasons why the callers contacted the helpline. The most frequently cited reason, at 56.5%, was to obtain general information about the SH relinquishment process. Almost over 14% of the callers contacted the helpline regarding information about adoption and 9.3% of callers contacted the helpline seeking information on how to relinquish an infant. Table 4 provides examples of case narratives for all of the categories.

Table 2 Characteristics of caller to a Safe Haven Helpline

Characteristic of caller	*n*	%
How heard of hotline (n = 158)		
Another hotline	11	6.96
Brochure	4	2.53
Crisis pregnancy center	11	6.96
Friend/word of mouth	7	4.43
Internet	105	66.46
Previous contact	8	5.06
Radio	1	.63
Social services	3	1.90
Other	8	5.06
Calling about self/other (n = 108)		
Self	78	72.2
Other	30	27.8
Pregnant (n = 388)		
Yes	50	12.9
No	164	42.3
Unknown	174	44.8

Actions Taken by the Hotline Staff and Outcomes

Table 5 displays information concerning what actions were taken by the staff on the call and what outcomes occurred. The first column shows the different types of actions and outcomes. This is followed by a repeated three column sequence, displaying the number and percent for each category of actions and outcomes, first for all callers, then for those calling specifically for information or action regarding SH relinquishment, and finally for information about adoption. For all callers, the action which staff did the most, 23.4%, was refer callers for information about adoption. The second most popular action, at 19.2% was making a referral to an internal contact within the NSHA network and a close third, at 18.1%, was instructions on how to relinquish an infant.

Table 3 Reasons someone calls a Safe Haven Helpline (total reasons, n = 453)

Reasons for Call	*n*	%
Adoption info	62	13.7
Business call	41	9.1
Education info/resources	5	1.1
Pregnancy-related	11	2.4
Safe haven relinquishment: general info	256	56.5
Safe haven relinquishment: instructions	42	9.3
Seeking help, not safe haven-related	30	6.6
Other	6	1.3

Table 4 Examples of reasons someone calls a Safe Haven Helpline

Category	Example
Adoption	Caller requesting adoption placement for 10-month-old daughter, is unable to care for her and would like to place her with adoptive family. Contacted Gladney Center to assist, working with mother
	Caller delivered baby at home yesterday and had not known she was pregnant or what to do after. She connected with American Adoption and did not know about Safe Haven. AA directed caller to drop the baby of at hospital and they would send her papers to fill out. The hospital did not know how to facilitate, took her name and number, and caller left. Today AA told her to fill out paperwork and fax back and for this she needed to go to hospital. When arrived hospital caller informed is involved and she will have to contact them. Security took her name and information while she was crying and scared. She said AA had called while we were on phone and she would call me back after speaking with them. Infant placed for adoption, mother involved
Business call	No examples provided
Education/training	CPC requesting SH education and possible partnership for supporting crisis situations. Education provided by email
	Hospital calling, wanting some safe haven information sent to them
Pregnancy-related	Pregnancy test
	Ultrasound
Safe Haven relinquishment: general info	Woman called asking for SH information, she is not due until February and is unsure if she is able to care for this baby. Information about MD SH law provided, adoption and parenting options also discussed. Caller stated she would call back if needed further information or assistance
	Woman called asking for SH information, at this time baby is in hospital, delivered 9/24/19 and mother is asking for help to SH the baby. Mother hid pregnancy from all, does have a 4-year-old daughter she is parenting at this time, newborn has no drug exposure per mother. Woman states she left an abusive relationship and is fearful for her child, wants a safe alternative for her. Chose Safe Haven surrender for infant, baby taken to hospital
Safe Haven relinquishment: instructions	Call from mother at hospital, requesting SH information after delivery. Mother stated she did want to do SH and was provided info as well as process given to staff at hospital. Mother did surrender infant
	Call from a woman stating her daughter is pregnant and is unable to care for her twin babies and wants to give the babies to the father after delivery. She wants to relinquish her rights and asked if she can surrender using Safe Haven and give the father's information

Table 4 (continued)

Category	Example
Call for service or help	Mother had a stroke when delivered her baby prematurely in 2017. The father took the baby home and is raising the child, she has not seen her baby in over a month and wants help to see her child and know she is okay. Mother has paralysis and is unable to have formal custody agreement. Hotline provided number for Dept. of Child and Families
	Requesting information on how to get baby back from CPS. Grandmother and mother calling from hospital, baby born 2 days ago in hospital. Police and CPS waiting after delivery. Father of child recently investigated for child porn because of case infant removed from mother and father custody. Mother trying to find assistance and housing. Mother had mental issues and unknown in child returned to mother
Other	Call from hospital transferred to mother, process give for inpatient, baby drug exposed and mother refused to choose an adoption plan at hospital. DCS involved and took custody of infant
	Asking why hotline told father of her 3-year-old that she should not give the child back to the mother.

These actions are similar to what happened for those who called for information about or instructions on how to relinquish an infant. The main difference is a higher percentage of those callers, 27.9%, received instruction on how to relinquish

Table 5 Actions and Outcomes Taken by Helpline Staff

Category	All callers[1] ($n=94$ Actions)		Safe Haven callers[2] ($n=43$ actions)		Adoption callers[3] ($n=128$ actions)	
	n	%	*n*	%	*n*	%
Action taken						
Instructions on how to relinquish infant	17	18.1	12	27.9	2	7.1
Referral to adoption agency	22	23.4	11	25.6	17	60.7
Referral to internal contact/NSHA network	18	19.2	7	16.3	3	10.7
Referral to local child protection agency	16	17.0	6	14.0	2	7.1
Referral to outside agency	9	9.6	2	4.7	1	3.6
Follow-up	10	10.6	5	11.6	3	10.7
Other	2	2.1	–	–	–	–
	($n=42$ outcomes)		($n=26$ outcomes)		($n=18$ outcomes)	
Outcome						
Adoption	18	42.9	8	30.8	14	77.8
Keep child	7	16.7	2	7.7	2	11.1
SH relinquishment	17	40.5	16	61.5	2	11.1

[a]Total number of actions taken among 76 cases

[b]Total number of actions taken among 41 cases. There is missing data on 9 cases

[c]Total number of actions taken among 62 cases. There is missing data on 39 cases

an infant. With regard to those who called for information about adoption, 60.7%, received information about that option. Significance testing was not performed between these groups because of the low sample size. Further, there is overlap between these two subgroups, with $n=9$ cases being present in both the SH group and in the adoption group.

A small percentage of cases had information about outcomes. When all callers are considered, the percentage of those who end in SH relinquishment versus adoption are roughly similar, 40.5% and 42.9%, respectively. The outcomes for individuals who called about SH information or relinquishment instructions leaned more heavily toward relinquishment as an outcome at 61.5% of callers. On the other hand, among those who called for information regarding adoption, in 77.8% of cases, it ended in adoption. Significance testing was not performed between these groups because of the low sample size.

Discussion

This paper documents the first analysis of calls to a helpline dedicated to SH and infant relinquishment. It examined the characteristics of callers who contacted the helpline, their reasons for calling, the actions taken by the staff, the case outcomes, and how those outcomes and actions varied by reason for call. The results showed that even though the helpline focuses on SH options and information, the helpline received calls that address a wide variety of issues. Only 65.8% of calls are actually about SH information or relinquishment, with the remaining calls about adoption and other supports and services.

Reasons for Calls

One of the most important findings of this study is the variety of reasons that individuals called the NSHA hotline. Given the focus of the hotline, one might be tempted to think that the calls would mostly address infant relinquishment. Instead, the reasons for calling reflect the wide variety of concerns of individuals who are dealing with a pregnancy or infant that they cannot support or manage. Other crisis-type helplines have found that callers sometimes seek assistance for problems that are beyond the scope of the helpline. For example, one study of crisis lines found that 18.7% of callers needed assistance with base needs and 13.7% called for "other" reasons (Kalafat et al., 2007). This finding demonstrates that staff who take the calls for the NSHA helpline must have a versatile set of skills and a wide knowledge base in order to adequately assist callers. Indeed, the skills and approaches of helpline volunteers is something that has been noted by others as well, especially with regard to fostering these approaches and in terms of promoting positive outcomes for callers (Kinzel & Nanson, 2000; Mishara et al., 2007).

Actions Taken and Outcomes

Most of the time, 69.2% of the time, callers are referred to or connected with another resource. Only 18.1% of the time are callers provided information on how to relinquish an infant. Referring callers to other resources is a standard practice of helpline staff. One study reported that among non-suicidal callers to a helpline, almost 60% were given a referral to a resource that could help them (Kalafat et al., 2007), which is in keeping with the results of this study. Further, many callers received a different type of support than the support that they called about. Previous research has emphasized the importance of problem-solving skills by hotline staff (Ingram et al., 2008). Others have presented that collaborative problem-solving between callers and crisis line staff are related to positive outcomes (Mishara et al., 2007). This includes asking fact-based questions about the problem at-hand, learning about the callers' resources and precipitating events, developing a plan of action together, and providing referrals to other resources. This is the kind of support that is provided by NSHA. To further add to the complexity of hotline work, staff often do not know the outcome of the support that they provide to callers (Kinzel & Nanson, 2000). This is the case for the NHSA hotline as well. For the 388 callers, there is only information on outcomes for 42 callers, half of which chose adoption and half chose SH.

Policy Implementation

For decades scholars have attributed policy failures to poor policy implementation (Gunn, 1978; Nakamura & Smallwood, 1980). Work in this area continues today (Hudson et al., 2019; May, 2015), with added focus on the efficacy or evidence-based that policies are not only implemented, but effective (Mehdizadeh et al., 2017; Weaver, 2010). Recent work in this area has stressed the capacity to implement new policies—the staffing, resources, and training that are involved and required in order to successfully implement new legislation (Hudson et al., 2019). There are several different ways that SHLs are implemented, including broad-scale public education and training professionals who will potentially be the receivers of infants being relinquished (Douglas, 2016). Illinois also provides targeted education, where information about SHLs is integrated into the high school health education curriculum (Save Abandoned Babies Foundation, n.d.). The NSHA hotline is an additional key element of the implementation of SHLs, since they provide guidance, direction, and support for families seeking to relinquish an infant. As policy practitioners, today's research guides us toward policy implementation in order to guarantee policy success (Hudson et al., 2019). In addition, the results of this study provide new information about parents who are in distress, the variety of different services that they need, and what happens when they want to relinquish an infant or find a permanent home for their child.

Limitations

There are several limitations of this study. First, while the overall sample size is reasonable, there are instances where the data is missing, which results in some small

cell sizes. For example, there is significant data missing concerning actions taken by the staff and outcomes of the cases. This is common among case management and health-related records (Anderson, 2020; Gomila & Clark, 2020; Piri, 2020) and even for hotline records (Lee et al., 2019). Given the descriptive nature of our analyses, we did not correct for this limitation. The staff could be trained to take more detailed case notes, but it is unlikely that records of the outcomes will improve substantially. Most of the time, staff do not know the outcomes because encounters with callers is brief. This is consistent with other research on hotlines as well (Kinzel & Nanson, 2000). Second, the year 2018 is the first year that NSHA kept case records on the calls that they received. The staff were still developing a system of record-keeping and the information gathered was not especially systematic. We were able to offer some modifications to their processes, which have improved their systems, starting with the year 2020.

Conclusion

This study provides the first analysis of callers to a hotline that focuses on infant relinquishment. The results show that for this one, small-scale hotline, callers seek help for a wide variety of reasons, seeking resources, support, and options pertaining to pregnancy, parenting, and caring for an infant who they are unable to parent. Although focused on infant relinquishment, the hotline staff support callers with varied options and help to develop plans for a positive and satisfactory outcome. Like many other hotlines, the NSHA hotline plays the role of policy implementer of SHLs. But, the results of this study also show that data from the NSHA hotline provide information for policy practitioners and policy- and decision-makers concerning the needs of vulnerable families. The results demonstrate the types of supports that are needed to promote stability for families and where future legislation, which sponsors the right combination of family supports, might reduce the need for infant relinquishment in the future.

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