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A Quantitative and Qualitative Analysis of an Adolescent "Warm Line"

Juno Brian Walter Stewart

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Master of Public Health Thesis

A QUANTITATIVE AND QUALITATIVE ANALYSIS
OF AN ADOLESCENT "WARM LINE"

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2000
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Before…

After!

Overall, I share this accomplishment with All My Relations.

I take refuge in the Buddha, the one who shows me the way in this life.
I take refuge in the Dharma, the way of Understanding and Love.
I take refuge in the Sangha, the community that lives in harmony and awareness.
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Introduction

“Adolescence is a developmental period of rapid physical, psychological, sociocultural, and cognitive changes characterized by efforts to confront and surmount challenges and to establish a sense of identity and autonomy” (DiClemente, Hansen & Ponton, 1996, p.1). This process can create problems for adolescents based on the shifts in behavior from childhood identification to the freedom of adulthood and its accompanying responsibilities. The establishment of close relationships with peers becomes important as the teenager strives to achieve an identity separate and distinct from his or her parents.

One problem is that unfortunately for teenagers today our nation is confronted by many social ills that are significantly different from previous generations, especially in terms of the life-threatening epidemic of HIV infection and AIDS. “The continued breakdown of the family, drug and alcohol abuse, rampant violence in our communities, inadequate health care, unemployment and poverty, and an increase in sexually transmitted diseases (STDs) are social forces that may hinder an adolescent’s abilities to develop healthy coping mechanisms” (Schondel, Boehm, Rose & Marlowe, 1995, p. 123).

Communication is key for these teenagers. The problems of concern for health care providers are that adolescents need to communicate with someone they can trust, and who is well informed about the strategies for dealing with complex social and behavioral issues. Adolescents often seek this advice and counsel from their peers (Schondel et al.,
1991). “Much of the adverse health consequences experienced by adolescents are, to a large extent, the result of risk behaviors…as such, they are preventable” (DiClemente et al., 1996, p.1).

Statement of Problem

In light of these two factors, adolescents separating from parents and valuing peer relationships, adolescents are inclined to seek other age-mates with whom to discuss problems rather than confiding in a parent or other adult figure (Boehm, Chessare, Valko & Sager 1991). Health care professionals who provide social and behavioral health care to adolescents have had problems in developing accessible and acceptable means of communicating with adolescents in an attempt to offer them prudent health care guidance and accurate information.

Statement of Purpose

“To help alleviate the gap in adolescent health care, a number of communities have established adolescent hotlines that provide listening and crisis intervention services” (Schondel et al., 1995, p. 124). It becomes a problem for the teen hotline when the community knows about the hotline, but the at-risk group that the program is designed to serve are not utilizing the hotline line or has knowledge that it exists. “Especially with ‘hard-to-reach’ groups, maintaining high hotline use rates often depends on the efficacy of an intensive media approach” (Walters & Finn 1995, p.272). This thesis describes the author’s experience with Teen Against Negligence (T.A.N.) and the T.A.N. Teen Help Line and its efforts to provide outreach to its community members.
Teens Against Negligence (T.A.N.) is a support group for HIV infected, affected and at-risk teenagers that formed to discuss and share issues affecting teens in a confidential and informal setting. The T.A.N. support group’s main goals were to learn more about themselves, HIV/AIDS education and prevention and related topics such as adolescent sexuality, alcohol and substance abuse. T.A.N. has developed the Peer Educator Training and Peer Support Group, the Teen Help Line and a Youth Speakers’ Bureau to accomplish its missions. Two social work interns from The University of Connecticut School of Social Work created the Peer Educator Training Guide and curriculum.

Clara Acosta-Glenn (personal communication, March 24, 2000), the Coordinator of the Infectious Disease Family Support Services, stated that a collaboration with The University of Connecticut and The Connecticut Children’s Medical Center (UConn/CCMC) HIV Pediatric and Youth Program provided medical services to children, youth and families living with or infected with HIV/AIDS. The UConn/CCMC Hospital’s Infectious Disease Pediatric and Youth Family Support Services (UConn/CCMC ID Family Support Services) developed, paid and trained staff to provide the T.A.N. training sessions at T.A.N.’s offices in Hartford at the Institute of Living. The ID Family Support Services Youth Program is funded by Ryan White IV through the Connecticut Primary Care Association.

Teens who participated in the Peer Educator Training received an in-depth understanding of a broad range of health and social issues affecting teenagers. After the
completion of T.A.N. training teens became Teen Help Line listeners and staffed the telephone hotline.

Overview

This thesis incorporates qualitative and quantitative analyses of telephone services that provide for adolescents’ physical and mental health needs in order to gain insight and better identify critical elements of program design and operation and to make recommendations to improve “warm lines” for the health and well being of adolescents. A review of hotline and “warm line” literature, making comparisons and providing observations and thematic findings based on program design and implementations will help readers gain a better understanding of adolescent telephone services. In addition, the Teen against Negligence Help Line will be presented as a local model.

The following chapter reviews literature on “warm lines” and hotlines that provide services to adolescent callers. The third chapter will describe the study methods. The results are presented in Chapter Four. Chapter Five presents the discussion section, Chapter Six the conclusions followed by recommendations in Chapter Seven.
Literature Review

History of Hotlines

The word “hotline” was defined by Morris (1976) as: “A direct communications link, as a telephone line, especially one between heads of government for use in times of crisis, as to prevent unintentional war” (p.637). The word “hotline” transitioned from an international world crisis focus to a more personal crisis focus.

America’s first community volunteer “crisis hotline” was San Francisco Suicide Prevention (SFSP) established in 1963 to provide telephone intervention to people experiencing suicidal crises. SFSP expanded its services from strictly suicide prevention to providing services 24-hours with a Drug Information and Relapse Line, AIDS/HIV Nightline, and Linea Nocturna providing support for Spanish speaking callers in crisis (“San Francisco,” 2000). As new societal crises are identified that affect a segment of the population, hotlines have developed to organize and address the concerns and needs of the population at-risk.

The Gay Men’s Health Crisis (GMHC) was the first AIDS Hotline, opened in 1981, to raise money for research on AIDS, provide information, volunteerism and support at a time when little information was known about AIDS. GMHC has expanded its services to advocate policy in favor of people with AIDS, to provide an educational department and to support an extensive volunteer network (Maslanka, 1995).

The first Federal government-funded hotline was the National Domestic Violence Hotline. President Clinton instituted the 24-hour, 365 day a year, toll-free hotline in 1996.
The National Domestic Violence Hotline operates across the United States providing crisis intervention, support and referrals to callers for services in their local community. The Violence Against Women Act, as part of President Clinton's 1994 Crime bill, created monies to establish a comprehensive response system to address access to services in an attempt to stem the criminal and public health epidemic of domestic violence ("National Domestic," 2000).

**Warm Lines**

Special needs “warm lines” are a new classification of hotline that resists simple classification because “warm lines” may include several service categories: information, prevention, entertainment, and crisis intervention. Phone Friend and Kid Call are examples of special needs “warm lines” (Goud, 1985).

Phone Friend was an adult volunteer-staffed, after school reassurance program for “latchkey kids” at home alone without adult supervision. Phone Friend was affiliated with Southwest General Hospital in a suburb of Cleveland, Ohio ("Phone Friend," 1991). Southwest General Hospital modeled the Phone Friend reassurance program after one developed by the Chapter of American Association of University Women from State College, Pennsylvania. Phone Friend got its funding from donations by hospital auxiliaries, community organizations, PTA groups and the Stop and Shop supermarket chain as corporate sponsors ("Phone Friend," 1991).

Phone Friend’s trained volunteer staff answered calls from children needing help with homework, problems at school, scary noises or who just wanted to talk to someone.
Teens called about drug, alcohol abuse and pregnancy issues. The phone line was designed for non-emergency issues and emergency calls rarely occurred. Phone Friend had success promoting Phone Friend to children through a spokesperson, a cartoon character named “Ziggy” who “reminds children that a friendly volunteer is just a call away” (“Phone Friend,” 1991, p.30).

The hospital packaged the Phone Friend programs, created seminars for marketing to other hospitals throughout the country and collected licensing fees to cover the cost of its Phone Friend service. The author touted the Phone Friend service as a prime resource to the community. Phone Friend was promoted through on-going feature stories as part of the hospital’s media relations with local media outlets and also through listing in the weekly “health calendar” column of the local newspaper. Phone Friend used public service announcements on television and radio stations, and also ran ads in area school system publications. By 1991, Phone Friend had received more than 11,000 calls per year and a total of nearly 60,000 calls (“Phone Friend,” 1991).

Kid Call was a support line for “latchkey” children home alone after school affiliated with The Lucile Salter Packard Children’s Hospital at Stanford, California (“Kid Call,” 1996). The Kid Call program was structured after a similar program from another hospital. Funding was provided through grants from corporate sponsors: Sega Foundation, Toy-R-Us and their media sponsor KGO-TV. The trained staff of volunteers received calls from third to sixth grade children who were without adult supervision after school. The hospital saw a need for a free non-emergency telephone support service to provide callers help with homework, and to discuss daily life, school problems and story
telling. Parents can also call to inquire about referrals or ask questions of trained nurses on staff.

Media outreach was accomplished through a collaborative project between Kid Call and the sponsorship of a major television station. The television station ran two different public service announcements (PSAs). One was for unveiling the Kid Call program and the other was for recruitment of volunteers. Kid Call also had PSAs run among pre-film slides at two movie theaters. The PSAs movie slides did not increase calls received but did gain the program and the hospital recognition. Kid Call improved the hospital’s status and identity for caring about children in the community and had a positive impact on the use of pediatric services (“Kid Call,” 1996).

Kid Call also had a partnership with the region’s school districts and did direct marketing to children through school distribution of refrigerator magnets, ads, brochures and flyers. The school district newsletter promoted the service along with health fairs and school events. Kid Call found that...“a tremendous number of health fairs and school events...proved to be more effective than the movie theater ads” (“Kid Call,” 1996, p.17).

“Warm lines” are increasing in number as self-care or “latchkey” children grow in number across the country. Health care professionals and hospitals have recognized the growing necessity to provide direct services for these children. Calls from adolescents to hotlines affiliated with hospitals have a history dating back some 30 years. A number of years have passed but adolescent callers have the same need to talk to someone and ask the same questions about homework and crisis disclosures such as sexual and physical
abuse (Walters, 1995). The needs and questions of adolescent callers have changed over time and the response of health care professionals, hospitals and “warm lines” have to keep pace with problems facing adolescents today.

**History of Warm Line and Hospital Affiliation**

An early review of “warm lines” describes the history of health professional and hospitals working together to provide relief for adolescent’s emotional and physical health. Diane Judge (1971) reviewed hotlines affiliated with hospitals and dealing with medical problems of community residents. The Childrens Hospital of Los Angeles was the first youth-oriented hospital “warm line” developed specifically to provide creative listening and crisis intervention to teenagers aged 17 to 20 years old. The hospital developed the “warm line” in response to consumer needs. The “warm line” was run by the hospital’s division of adolescent services. This “warm line” is of importance because this was the first model of a “warm line” that provided listening and crisis intervention service specifically designed for adolescent callers.

Judge (1971) states that creative listening was used by the “warm line” listeners to explore solutions based on the callers frame of reference. The ability of listeners to “read between the lines” with a “third ear” to a caller’s problem was important. The biggest success for the “warm line” was the connection made between the hospital’s staff and the adolescent callers in providing a safe, helpful and confidential hotline. The major reason for the hotline’s success was the organization’s ability to rule out listeners who are judgmental, give their own opinion or control adolescent caller’s decision making. Most
of the calls to the “warm line” were from 14 to 20 year old girls. The two most common reasons for calls were with boy-girl relationships and family conflict. Next were problems with drug abuse, pregnancy, venereal disease and the draft, but with less frequency.

Health professionals and hospitals have identified health problems of specific community members and have allied themselves with “warm lines” to provide telephone services to that population in order to provide a needed service for combating the specific problems identified.

The Eating Disorders Hotline was a “warm line” that dealt with specific health problem and offered health professionals insight into how to reach a specific community and to make gains in providing direct services to overcome the source of the health problem. The reason for the hotline service was to provide peer to peer anonymous referrals for socially shy male and female callers who might not use more formal clinical intake services for help (Burket & Hodgin, 1989).

The Eating Disorders Hotline offered an overview of adolescent telephone training and promotional activity to accomplish the goal of effecting a positive change in community awareness and in making referrals for callers for eating disorders. Training consisted of meetings and seminars discussing eating disorders, diagnostic criteria, weight charts, role-play, emotional and physical problems associated with the types of calls received and referral sources.

Roger Burket and Jon Hodgin (1989) wrote about their initial experience with implementing an Eating Disorders Hotline. The University of Florida-Gainesville Health
Centers Eating Disorders Clinic, provided training and supervision to campus Clinical Dietetic Student Association members who volunteered to answer telephone calls from college students and community residents who had eating disorders, including bulimia nervosa and anorexia nervosa.

Media attention, active listening skills of volunteers and referrals made regarding general eating disorders increased the students and general public awareness of eating disorders. Local newspaper, radio and television stations promoted the hotline through public service announcements (PSAs). Paid ads were run on a regularly scheduled basis in the university newspaper. Several workshops were held in conjunction with hotline media outreach attempts (Burket & Hodgin, 1989).

It was not possible for the hotline service to determine its impact on the callers because the volunteers were unable to follow-up on the acceptance of referrals made to hotline callers. The callers were anonymous and thus the only way to address outcome was the callers’ self-report of a hotline referral to the Health Center’s Eating Disorders Clinic. This proved that callers delayed accessing the Eating Disorders Clinic treatment for months after referrals were made (Burket & Hodgin, 1989).

Burket and Hodgin (1989) evaluated the Eating Disorders Hotline and concluded that the cost of newspaper announcements and training material were minimal; personnel costs were negligible because the telephone was manned by student volunteers; facility costs were low because they were provided by the student mental health services. In terms of student volunteer time and energy there were human cost but...“we felt that this
project made a worth-while contribution to the university community and should be considered in other universities and communities settings as one aspect of an overall eating disorders treatment program” (Burket & Hodgin, 1989, p. 185) The authors stated that volunteer services were readily available to provide an empathic ear and to make referrals for information but that the service had to be carefully tailored to other settings before implementation.

Comparison of Warm Lines

Teen Line and Teen Hot Line are adolescent telephone listening services that most closely fit the “warm line” model of T.A.N. Teen Help Line. The Teen Hot Line provided evidence that adolescents were in need of peer to peer communication and the benefit to student volunteer and caller health and wellbeing was documented. The Teen Line was one of the teen listening services that was cited in many studies for its use of adolescents as telephone operators. It was recognized as an effective source for disseminating health related information. The comparison of Teen Line and the Teen Hot Line to similar adolescent “warm lines” telephone services offers useful information on their use of adolescent operators and the promotional activities that are included in their program design and health communications.

Dolan (1995) described a volunteer telephone service staffed by high school students called Teen Hot Line in Campbell River, British Columbia, Canada. The author conducted a Student Needs Assessment Survey of teens in four secondary schools about their opinions and suggestions on a teen hotline and found that a crisis line would provide
to a significant number of teens a needed service. An Alcohol and Drug Program provided a grant for a 10-week pilot project that ran from April to June 1992. Peer counselors were trained in the initial operation of the hotline during a three-day seminar focusing on telephone rapport and role-play. Four secondary schools were the target of promotions, recruitment and training of adolescent volunteers. Then the peer counselors trained student volunteers from the four schools to serve as confidential hotline operators to troubled teens. A program manager was hired to provide training, transportation and to serve as a resource to telephone operators. Another grant provided funding for 1992 to 1993 that included a two-day training for 65 student volunteers, transportation allowances and snacks for the volunteers and staff development, training material, rent and operating expenses.

Dolan (1995) studied the attitudes of volunteers using The Piers-Harris Self-Concept Scale and found that adolescent volunteers were caring, considerate and willing to invest time in helping others and increased their scores of caring, consideration and willingness to help others over a 6 month period. The outcome evaluation concluded that calls from volunteers, school counselors and anonymous callers were consistently supportive. In terms of utilization there were almost 5 calls per week. Student volunteers benefited from their altruistic involvement in the hotline and teen callers confirmed the necessity and acceptance of the hotline, which resulted in a valuable relationship for both the callers and student volunteers.

Boehm, Chessare, Valko and Sager (1991) published a descriptive analysis of Teen Line, a telephone listening service for adolescent callers structured, in part, on an
existing adult crisis line. In its first year of operation the authors found that Teen Line received 2,270 phone calls. Of these calls, 4% of callers discussed crisis situations (physical abuse, suicide), and the rest were concerned with adolescent topics that were less urgent (peer relationships, family dynamics and just to talk to someone). The authors documented that after an initial novelty effect, consistent levels of telephone calls to the service demonstrated its acceptance as a source of information and support for adolescents.

Boehm et al. (1991) described the one-year study of Teen Line, a Toledo, Ohio based teen listening telephone service founded by a local church youth group. The Teen Line was staffed by adolescent phone call answerers (PCAs) and adult back-up persons (BUPs), who almost never answer the phones but were reserved as a resource to PCAs staffed the Teen Help Line. The target populations for Teen Line were adolescent high and junior high school students. The reason for Teen Line’s development was to provide accessible, current and acceptable information for guidance to teen callers from peers. Twenty-two teens completed 66 hours of training. This included an 18 hour overnight stay initial session for community building and 10 Saturday sessions that provided training on: peer relationships, family dynamics, suicide, sexuality, drugs and alcohol abuse, mental illness, spirituality and death. Also teen listeners were trained on the use of referral sources for therapy and other health services for teens.

Boehm et al. (1991) established that Teen Line was an accepted and useful service for the target population as evidence by its continued use as an effective way to disseminate information to teens. The most common reason for calls were peer
relationships and the need of callers to have someone “just to talk to.” The “hot topics” of school educators or the mass media were not the topics that adolescent callers wanted to discuss with PCAs. The mass media and formal education system’s “hot topics” were teen pregnancy and substance abuse, but teen callers infrequently wanted to talk about these subjects. The authors’ data reveals that peer telephone help lines (that provide peer listeners who use problem-solving techniques) were an acceptable source of disseminating information to adolescent callers (Beohm et al., 1991).

Boehm, Schondel, Marlowe, and Jared Rose (1995) described gender, age and seasonal variations in calls to Teen Line. The authors reported that there were significant gender, age and seasonal variations when compared to the calls in total. The authors described variations in calls from males and females. Male callers were more likely to call about sexuality, mental illness or “just to talk.” Female callers were more likely to call about family issues, peer relationships, abuse, pregnancy and eating disorders than males.

The authors segmented the adolescent callers into three age groups: early adolescent (11-13), mid-adolescent (14-16) and late-adolescent (17-19). Early adolescents (11-13) called regarding family problems, school problems and peer relationships. Mid-adolescents (14-16) called about suicide, abuse, sexuality and pregnancy. Late adolescents (17-19) called about drug and alcohol, mental illness, death, spirituality and “just to talk” (Boehm et al., 1995).
The authors also examined seasonal variation: December-February, winter; March-May, spring; June-August, summer; and September-November, fall. Calls about suicide, abuse and death were more likely in the winter and spring; calls about family dynamics were more likely in the winter; peer relationships calls were more likely made in the spring, eating disorders calls were more likely to be made in the spring and summer. Mental illness calls were more likely to be made in the summer and winter. Calls because of school problems were more likely in the fall, winter and spring. Calls made “just to talk” were more likely in the fall (Boehm et al., 1995). The authors concluded that by knowing what data to focus on and what’s of concern to adolescent callers health care providers and peer to peer help lines can anticipate problems and offer better guidance to adolescents (Boehm et al., 1995).

Schondel, Boehm, Rose and Marlowe (1995) conducted a national survey of adolescent hotlines and 54 teen hotlines responded out of 75 to the survey. The 54 teen hotlines responding 92% provided both crisis and listening services. The data identified that 22% (12) of teen hotlines used only adults to answer calls; 44% (24) used only adolescents; 33% (18) had both adults and adolescents answer the calls. If the phone line used only adolescent phone call answers (PCAs) to answer calls 79% (19) of these organizations had adults as back-up persons (BUPs) answer in the place of adolescents for the following reasons: crisis situations such as drug overdose, reports of abuse or suicide; to assist adolescent volunteers with prank or harassing callers; and for times when there were no adolescent volunteers. Of all the adolescent teen hotlines only 5 used adolescent volunteers to answer all calls.
The authors used time zones to describe the location of the teen hotline organizations: 8 were located in the Pacific time zone; 1 was located in the Mountain time zone; 9 were located in the Central time zone; 35 were in the Eastern time zone; and 1 was in the Atlantic time zone. Teen hotline organizations were in operation for less than 1 year to 23 years, with 4 years being the median. The teen hotline hours of operation ranged from 1 to 5 hours (19), 6 to 10 hours (11), 11 to 15 hours (2), to 20 to 24 hours (22). Of those surveyed 44 (81%) indicated that they were operated at least 5 days a week (Schondel et al., 1995).

Training for the adolescents in these teen hotline organizations ranged from 20 hours to over 70 hours. The median training hours was in the 40 to 44 hour range. The authors found a positive relationship between the length of training time and the type of volunteer who answers the phone: “hotlines who only used adolescents to answer the phone received significantly more training than organizations who used both adults and youth volunteers and adults only” (Schondel et al., 1995, p.126).

Schondel et al. (1995) found that teen hotline organizations used school and church presentations, agency settings, word of mouth, television, newspaper and radio as ways to recruiting volunteers. All but one organization had paid employees in addition to volunteer staff and 39 (73%) were affiliated with another agency. Funding was provided by foundations, fundraisers, private donations and to a lesser degree public monies.
Research Setting

Teen Against Negligence (T.A.N.) provided the setting for this thesis. The methods T.A.N. used to organize and provide an important telephone “warm line” service to adolescents will be described. As mentioned earlier T.A.N. was developed through collaboration between the University of Connecticut and the Connecticut Children’s Medical Center (UCONN/CCMC) HIV Pediatric and Youth Program. The UCONN/CCMC hospital’s Infectious Disease Pediatric and Youth Family Support Services (ID Family Support Services) provided medical services for the testing of children being born to HIV positive mothers at their General Clinic. Newborn babies who test HIV positive receive HIV treatment and follow-up until 18-months of age. HIV treatment was provided in conjunction with ID Family Support Services Case Management and by primary care physicians. ID Family Support Services Maternal Child Clinic coordinated HIV medical specialist treatment for parents and children infected with HIV during the same visits. ID Family Support Services was seeking better treatment for infected adolescent, babies and pregnant women.

The ID Family Support Services Adolescent Program developed from the Maternal Child Clinic because there were children between the ages of 12 to 24 who needed a program that addressed adolescent concerns. The Adolescent Program provided a peer support group and Peer Educator Training for youth who were infected, affected and at-risk adolescents for HIV infection, AIDS and sexually transmitted diseases (STDs). The goals of the programs were for the adolescents to learn more about themselves; HIV/AIDS prevention and education; and topics that HIV infected, affected
and at-risk adolescents wanted to address. The adolescents created a new name and
direction for the Adolescent Group. Teens Against Negligence (T.A.N.) was the new
name chosen for the Adolescent Group. T.A.N. adolescents implemented the Teen Help
Line to provide peer support via the telephone to adolescents.

A brief description of HIV infected, affected and at-risk adolescents needs to be
included from the literature and from the author’s experience with T.A.N. adolescents.
The T.A.N. adolescents are primarily African American and Hispanic, between the ages
of 12 and 20, living in the greater Hartford area. The HIV infected adolescents come from
two populations. One group of T.A.N. members has been seropositive all of their lives
through vertical transmission and are involved in medical treatments which helped them
to reach the age of puberty. A second group contracted the HIV infection during their
adolescent. There are concerns for these two populations in that they may be engaging in
more risk behavior than their HIV negative counterparts. HIV positive adolescents were
significantly more likely to be sexually abused, engage in anal, oral and survival sex,
unprotected sex with casual partners, sex under the influence of drugs and use multiple
drugs, have a sexually transmitted disease, and engage in multiple problem behaviors
than their HIV negative counterparts (Hein, Dell, Futterman, Rotheram-Borus & Shaffer,
1995). HIV infection or AIDS affects a third group of T.A.N. adolescent because at least
one member of their family has HIV/AIDS. These adolescents are not “infected” but are
“affected” by the disease from experiencing HIV infections and/or AIDS related deaths of
family members, friends, and peers. Adolescents who are HIV/AIDS infected and
affected can be particularly vulnerable because of the emotional distress of facing family
problems, sick parents and siblings, conflict with separation and loss and all the while dealing with the difficulties and demands of adolescents. Infected, affected and at-risk adolescent are the target of T.A.N. interventions. “Only targeting adolescents living in high-risk situations would imply that other adolescents are not at risk, which is not true” (Hein et al., 1995, p.103).

The T.A.N. members wanted to provide prevention, education, support and outreach to at-risk adolescents in an effort to reduce or halt problems affecting adolescents in the Hartford, Connecticut community. The author was an intern at T.A.N. and a student in the Masters of Public Health program at UConn Health Center. The staff were paid and trained by ID Family Support Service to provide the Peer Educator Training sessions, supervised, provided snacks, lunches and transported adolescents when necessary and to coordinate the Teen Help Line at their offices in Hartford’s Institute of Living.

T.A.N. Teen Help Line had two groups of adolescents involved in the Peer Educator Training Program and Peer Support Group. In the first groups of adolescents there were 16 to 19 years olds and who were at the legal age to get paid for working. The second group of adolescents were 12 to 15 years old and they were too young to answer the help line phone but were taking the Peer Educator Training to prepare to work the Teen Help Line. The older group helps train the younger group based on their experiences and time spent on the help line. The identification with the older or younger group provided the adolescents with group cohesion that developed as a result of their separate
training group experiences. On any given Saturday the T.A.N. Peer Educator Training sessions had between 4 and 14 adolescents.

The author’s experience with T.A.N. adolescents during his internship offers some insight into who they are, how they perceive their world, what they are concerned about and how this fits with the population being served by the “warm line.” T.A.N. adolescents are HIV infected or affected but an outsider would not think this from all the giggling, teasing and loud talk during the Saturday morning breakfast of grapes, candy, snacks and juice. Some of the group members are quieter than others but speak up when a topic strikes a cord in them. They are street smart and use slang to express themselves. When the author brought up the topic of HIV and AIDS during a Peer Educator Training on dealing with your own emotions, the group members squirmed in their seats. The squeamishness came not from talking about sex but the idea of disclosing their seropositive status to the group. There were no disclosures of adolescent serostatus to the author either from the staff or from the T.A.N. adolescents. The only case of disclosure known to the author came during an exchange between two adolescents at the Peer Educator Training in which one of them stated that they knew what the pillbox the other had on her key chain was for because he had one too. “Adolescents living with HIV do have a different set of concerns, including issues related to disclosure of their HIV status to family, partner(s), friends, and community” (Hein et al., 1995, p.103). In the case of the 1997 Summer Youth Research Institute, adolescents were concerned about the topics of stress, money, peer pressure and the central theme of “image” while adults decided that HIV/AIDS would be the central theme of the institutes research (Bojko & Acosta-Glenn,
T.A.N. adolescents still perceive their world as not safe to come out about their serostatus, which hinders the program design. The Teen Help Line listeners do not want to talk only about HIV/AIDS because it limits who they are as people with HIV infections or affected by a primary relationship to someone with HIV/AIDS. The T.A.N. adolescents’ topics and issues choices, ranging from family violence to financial problems, support their outreach efforts, “By raising awareness and compassion within the community at large, both the uninfected and infected young peoples’ lives would be improved” (Hein et al., 1995, p.103).

Ten adolescents completed the Peer Educator Training by attending nineteen three-hour sessions on consecutive Saturdays. The Peer Educator Training covered listening and communication skills, dealing with emotions, problem solving and decision making, role playing, cultural diversity, careers and money, teen suicide, sexually transmitted diseases, facts about HIV/AIDS, spirituality, death, dealing with adolescent substance abuse, adolescent development, sexuality and resources for adolescent services.

The staff trained the Teen Help Line listeners by providing guest speakers to lecture, lead large group discussions and small group role-plays. Training for adolescents to answer the help line calls was carried out through role-play, watching and listening, hands on training and ongoing training sessions. Group cohesion was developed through members of T.A.N. attendance at a Challenge Course that provided group work skills to solve problems and to offer members an experience of success and accomplishment.
T.A.N. adult staff acted as back-up persons (BUPs) to answer calls in place of the Teen Help Line adolescent phone call answers (PCAs) if there was a crisis or the caller was suicidal, had overdosed on drugs or was being abused either sexually or physically. T.A.N. Teen Help Line “PCAs” can ask for assistance from adult staff “BUPs” with prank calls or harassing callers. T.A.N. Teen Help Line adult staff answered the “warm line” when no adolescent was available. There was coaching done by staff during calls and after the phone conversations ended. Staff debriefed the adolescent phone operator in an attempt to offer suggestions for how to handle similar and future calls effectively.

After the completion of all the T.A.N. training a Teen Help Line Listener are certified to answer the “warm line.” The adolescents phone operators were paid $8 dollars an hour for their work on the “warm line.” One Teen Help Line Listener operated the “warm line” nightly from 5:30 to 7:30 p.m. assisted by one of the staff members.

A typical call to the T.A.N. Teen Help Line went like this. The phone rang and the Teen Help Line listener would answer in an articulate, professional and eager manner, “Teens Against Negligence Help Line, how may I help you?” The caller (who the author could not hear) spoke about how life and school was boring. The listener asked what the caller did for fun. The caller responded with “just hanging out.” The listeners said that she did the same thing. The caller asked what school the listener went to. The listener said, “Hartford High.” The caller went to a different high school. The caller asked how she liked the classes there. The listener said, “that the classes were O.K. and the best part was that the time went fast at school because she got out early.” The caller wanted to know how she did that and the listener said, “I scheduled my classes that way.” The caller
was interested in doing the same with his schedule next semester. The caller asked the listener her name. The listener turned to me in a look of puzzlement and said, “he wants to know my name.” She and I both know that giving out listeners’ real names are not permitted for security reasons. The author “coached” the listener by writing on a note pad, “It is O.K. to make up a fake name, how about Mary.” She replied, “Mary.” The caller said his name was Jamul and he told her that it was nice talking to her and he would ask for her again when he calls. This call lasted for about 5 minutes. The listeners enter the call onto the T.A.N. Teen Help Line “listeners” Telephone Log. The listener rated the call as pertaining to (Q) life, with a severity of (3) routine and an outcome of (L) listen. A copy of the Teen Against Negligence Teen Help Line “listeners” Telephone Log is located in the Appendix.

Methods

The primary method for collecting data on the T.A.N. Teen help Line was by the caller log. Teen Help Line listeners recorded data on each phone call received. The listener recorded information on the Teen Help Line phone log form. The phone log required the listener to gather demographic information which included the name of T.A.N. Teen Help Line listener taking the call, name of caller if the caller disclosed, date of call and length of call. The listener was given a list of reasons to choose from and to check off on the form that described the reasons for or why the call was made. The choices to mark-off were: abuse, AIDS, alcohol, career, depression, divorce, drugs, education, employment, family life, future, gangs, goals, guns/weapons, homelessness, homosexuality, life, medications, money, nutrition, parents, peer pressure, prank,
pregnancy, sex, STDs, and suicide (further qualified as: specific, lethal, accessibility, proximity). The listener determined the severity of the call from a range of severe, moderate or routine. The listener had to choose from three outcome measures based on their interaction with the caller: listen, information or referral. Sometimes the listener chose more than one outcome measure. There was no collaboration between listeners to make an assessment of the outcome measures. The listener had a space on the phone log form to make any notations about referrals given or important parts of the conversation with caller.
Results

Table 1 shows the chronology of the T.A.N. Teen Help Line. Table 2 presents the frequency distribution of the number of calls compared to the promotional activities per month over the initial 12-month period. The total number of T.A.N. Teen Help Line calls received from March 1, 1999, through December 31, 1999 was 86. There were 2 pre-program promotions. The greatest number of promotional activities in a month was 4. This occurred in the months of April and August with different outcomes in terms of calls recorded on the T.A.N. phone log. September, October, November and December T.A.N. records show no promotional activities were performed.

Table 3 shows a list of promotional activities and presentation that T.A.N. completed as of March 1, 1999 the start of the Teen Help Line. These promotional activities and presentations may have contributed to 13 additional adolescents joining the T.A.N. Peer Education Training after August 1999.

The frequency distributions of calls by the day of the week are presented in Table 4. The least number of calls were answered on Monday.

Table 5 displays the frequency of topics discussed by callers and the severity of callers concerns rated by the Teen Help Line listeners. The Teen Help Line listeners rated the 86 total calls received. Multiple reasons for callers concerns resulted in 93 reasons for calls received. The listeners rated as severe calls pertaining to life, family life, AIDS, homosexuality, drugs, STDs, parents, and goals. The most frequent number of calls received and subsequently rated as routine by listeners were related to prank or
incomplete calls, life, relationships, family life, AIDS and employment. Female callers made 29 calls and males made 11. There was no recorded determination of gender in 46 calls. The number of prank or incomplete calls was 15. The average time of the calls was 9.5 minutes. The average number of calls per month was 8.6. The average number of calls per week was 2.
**Table 1**

**Chronology of Teen Help Line**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>First group of adolescents in the Pediatric HIV program</td>
</tr>
<tr>
<td>Sum. 1996</td>
<td><strong>Needs Assessment</strong></td>
</tr>
<tr>
<td>Sum. 1996</td>
<td>Social work interns interview adolescents</td>
</tr>
<tr>
<td>Sum. 1996</td>
<td><strong>Program design</strong></td>
</tr>
<tr>
<td>Sum. 1996</td>
<td>Theory development</td>
</tr>
<tr>
<td>Sum. 1996</td>
<td>Short and Long term goals</td>
</tr>
<tr>
<td>Sum. 1996</td>
<td>Adolescent Support Group created</td>
</tr>
<tr>
<td>Sum. 1996</td>
<td>Conception of the Teen Help Line program and Peer Educator Training</td>
</tr>
<tr>
<td>Nov. 1996</td>
<td>Teen Help Line concept presented to Pediatric HIV program hospital affiliates</td>
</tr>
<tr>
<td>1996</td>
<td>T.A.N. funding created</td>
</tr>
<tr>
<td>Sum. 1997</td>
<td>T.A.N. created partnerships with other organizations</td>
</tr>
<tr>
<td>Sum. 1997</td>
<td>Assess survey of adolescents</td>
</tr>
<tr>
<td>1997</td>
<td>Adolescent recruitment efforts</td>
</tr>
<tr>
<td>Fall 1997</td>
<td>Peer support program developed</td>
</tr>
<tr>
<td>Jul. 1998</td>
<td>Peer Educator Training format created</td>
</tr>
<tr>
<td>Jul. 1998</td>
<td>Peer Educator Training started</td>
</tr>
<tr>
<td>Aug. 1998</td>
<td>T.A.N. program development for staff and operations of the Teen Help Line</td>
</tr>
<tr>
<td>Sept. 1998</td>
<td>Funding received for T.A.N. Teen Help Line</td>
</tr>
<tr>
<td>1998</td>
<td><strong>Staff hiring and development</strong></td>
</tr>
<tr>
<td>1998</td>
<td>Staff developed adolescent recruitment, training, certification &amp; supports</td>
</tr>
<tr>
<td>Dec. 1998</td>
<td><strong>Media activities</strong></td>
</tr>
<tr>
<td>Dec. 1998</td>
<td>Media strategies developed for Teen Help Line</td>
</tr>
<tr>
<td>Dec. 1998</td>
<td>First promotional activity for the Teen Help Line</td>
</tr>
<tr>
<td>Mar. 1999</td>
<td><strong>Implementation</strong></td>
</tr>
<tr>
<td>Mar. 1999</td>
<td>Start of the Teen Help Line</td>
</tr>
<tr>
<td>Apr. 1999</td>
<td>First presentation activity for the Teen Help Line</td>
</tr>
<tr>
<td>Jul. 1999</td>
<td>Author (Juno Stewart) started internship at T.A.N.</td>
</tr>
<tr>
<td>1999</td>
<td><strong>Evaluation</strong></td>
</tr>
<tr>
<td>1999</td>
<td>On-going evaluation of outcome measures</td>
</tr>
<tr>
<td>1999</td>
<td><strong>Program revisions</strong></td>
</tr>
<tr>
<td>1999</td>
<td>On-going program revisions by staff &amp; adolescent input &amp; outcome measures</td>
</tr>
<tr>
<td>Oct. 1999</td>
<td>Author (Juno Stewart) ends internship at T.A.N.</td>
</tr>
<tr>
<td>Dec. 1998</td>
<td>End of the Teen Help Line</td>
</tr>
<tr>
<td>Dec. 1998</td>
<td>Peer Educator Training scheduled to continue</td>
</tr>
</tbody>
</table>
Table 2

Number of Calls and Promotional Activities Per Month
(December 1, 1998 - December 31, 1999)
<table>
<thead>
<tr>
<th>Date</th>
<th>Promotional Activity</th>
<th>Medium</th>
<th># of People served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-98</td>
<td>The Hartford Courant</td>
<td>Article about T.A.N.</td>
<td>na</td>
</tr>
<tr>
<td>Dec-98</td>
<td>UCONN Health &amp; Science Magazine</td>
<td>Article about T.A.N.</td>
<td>na</td>
</tr>
<tr>
<td>Mar-99</td>
<td>Channel 61</td>
<td>Television News Story</td>
<td>na</td>
</tr>
<tr>
<td>Mar-99</td>
<td>CCMC Employee Newsletter</td>
<td>T.A.N. Description Ad</td>
<td>na</td>
</tr>
<tr>
<td>Apr-99</td>
<td>Manchester Inquirer</td>
<td>Article about T.A.N.</td>
<td>na</td>
</tr>
<tr>
<td>17-Apr-99</td>
<td>Channel 30 Adelante Show</td>
<td>Television 8-minute Interview</td>
<td>na</td>
</tr>
<tr>
<td>Apr-99</td>
<td>Panorama Magazine</td>
<td>Free Community Magazine-Ad of T.A.N.</td>
<td>na</td>
</tr>
<tr>
<td>1-Apr-99</td>
<td>Youth conference</td>
<td>Rushford Center</td>
<td>100 Youth</td>
</tr>
<tr>
<td>17-Apr-99</td>
<td>Health Fair</td>
<td>AIDS Project Hartford</td>
<td>60 Youth</td>
</tr>
<tr>
<td>12-May-99</td>
<td>Channel 3</td>
<td>News Story</td>
<td>na</td>
</tr>
<tr>
<td>Jun-99</td>
<td>AIDS Health Update</td>
<td>T.A.N. Description Ad</td>
<td>na</td>
</tr>
<tr>
<td>5-Jun-99</td>
<td>Health Fair</td>
<td>Latinos/as Contra Sida</td>
<td>80 People</td>
</tr>
<tr>
<td>15-Jul-99</td>
<td>Channel 5</td>
<td>Television 12-minute Interview</td>
<td>na</td>
</tr>
<tr>
<td>12-Aug-99</td>
<td>Health Fair</td>
<td>Hispanic Health Council</td>
<td>100 People</td>
</tr>
<tr>
<td>13-Aug-99</td>
<td>Channel 30</td>
<td>News Story</td>
<td>na</td>
</tr>
<tr>
<td>16-Aug-99 to 30-Aug-99</td>
<td>WLAT 1230 AM</td>
<td>Radio Headliners/Commercial in Spanish</td>
<td>na</td>
</tr>
<tr>
<td>16-Aug-99 to 30-Aug-99</td>
<td>JAMZ 910 AM</td>
<td>Radio Headliners/Commercial in English</td>
<td>na</td>
</tr>
</tbody>
</table>
Table 4

Number of Calls vs. Days of Week

<table>
<thead>
<tr>
<th>Day</th>
<th>Number of Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>12</td>
</tr>
<tr>
<td>Tuesday</td>
<td>14</td>
</tr>
<tr>
<td>Wednesday</td>
<td>23</td>
</tr>
<tr>
<td>Thursday</td>
<td>22</td>
</tr>
<tr>
<td>Friday</td>
<td>15</td>
</tr>
</tbody>
</table>
Table 5
Reason for Calls vs. Number of Calls

<table>
<thead>
<tr>
<th>Reason for Call</th>
<th>Severe</th>
<th>Moderate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexuality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Career</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guns/Weapons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

Observational and Thematic Findings—Utilization

From the author’s observations the T.A.N. Teen Help Line was a useful service to those adolescents in the Greater Hartford community who utilized the “warm line.”

Comparison with utilization data of phone lines in previous North American studies (Judge, 1971; Boehm et al., 1991; Dolan, 1995; “Phone Friend,” 1991), suggests that the T.A.N. Teen Help Line was underutilized. There were limitations when comparing utilization data Dolan (1995) writes, “The frequency and nature of calls vary and are influenced by such things as the Christmas season, term exams, or a specific high-profile tragic event such as teen suicide or car accident” (p. 199).

There were seasonal variations of calling patterns written about by Boehm et al., (1995) who identified callers “concerns regarding school problems were more likely during the school year” (p. 870). There was an initial novelty effect at the beginning of the Teen Help Line that accounted for the high amount of calls received in that time period. As expected from the literature, the Teen Help Line received more calls during and at the end of the school year. There was a high level of consistent use documented until the end of the school year. There were also many hang-ups and nuisance calls received at the Teen Help Line.

Boehm et al., found that most of the callers to the Teen Line were female (Boehm et al., 1991). The same results were found at T.A.N. Teen Help Line. The data were
incomplete data because gender was not recorded in the log forms of the Teen Help Line listeners.

**Observational and Thematic Findings-Callers Topics**

The data on the Teen Help Line listeners’ ratings of the frequency of callers’ topics concluded that life, relationships, family life, AIDS, employment and sex were of importance to the callers. These were the same topics and issues that the Teen Help Line listeners’ thought about when they decided to provide prevention and education services to callers. Callers’ topics to the Teen Help Line that were rated the most severe were relationships, family life and AIDS.

Studies of Teen Line revealed that callers’ concerns were similar to the Teen Help Line callers’ concerns: peer and family relationships, sexuality and the need to have someone “just to talk to” (Boehm et al., 1991; Boehm et al., 1995).

Boehm et al., (1991) described “hot topics” for both mass media and the educational systems as being teenage pregnancy and substance abuse. The authors were concerned about the relative infrequency of callers’ concerns with these topics. There were 4 calls to the Teen Help Line that identified callers’ concerns on each of the two topics, 2 calls for drugs and 2 calls for pregnancy. The infrequency of callers’ concerns about these topics may have been based on adolescents being exposed to intensive school education programs involving safe sex, abstinence and D.A.R.E. drug programs. Also there are many mass media efforts concerning adolescent drug education and teen pregnancy as topics on PSAs. The limited number of calls received on drug abuse and
pregnancy on the help line could indicate that adolescents were less concerned about seeking peer support on these topics (Boehm et al., 1991).

Observational and Thematic Findings-Promotions vs. Calls

In March, at the start of the Teen Help Line, 23 calls were received. The high rate of calls in March could be due to the two media promotions in December 1998 and an initial novelty effect as the help line started. During April the number of calls reduced to 14. In April and August the Teen Help Line had the most promotional activities with 4 each month. Eighteen calls were recorded in May and the number dropped to 5 in June. Acosta-Glenn (personal communication March 24, 2000) asserted that to overcome the deficiencies in the number of adolescents calling the help line, an increase in the numbers of presentations and promotions was needed to effect an increase in calls to the Teen Help Line.

A review of the amount and types of promotional activities in the month of April showed that the number of and types of promotional activities may have had the effect of increasing the rate of calls received by the Teen Help Line in April and May. The 4 types of promotional activities in April included: the Youth Conference at Rushford Center which had 100 at-risk youth; AIDS Project Hartford Health Fair which had 60 at-risk youth; The Adelante Show’s 8-minute television interview gave first person accounts of T.A.N. members and the Panorama Community magazine and that targeted T.A.N.’s audience in the local community magazine. These promotional activities targeted the at-risk adolescent audiences who have the most interest in T.A.N. membership and in the
Teen Help Line. In the month of May channel 3 television station ran a news story about T.A.N. as their health feature.

In June there was a sharp drop-off in calls to 5. The decline could be contributed to the end of the school year and the beginning of the summer vacation months. In June, July and August, the summer months, there was a small but steady increase in the amount of calls to the Teen Help Line.

Judge (1971) noted a different pattern of calls received during the summer months of The Help Line Telephone Center, in their first year of operation. The Help Line Telephone Center received a large number of calls during the summer months because vacationing students became bored and troubled as summer progressed. The vacationing adolescents in the Hartford community who may have been bored and troubled may have called the Teen Help Line, but caution is needed concerning these observations of summer months. The Judge (1971) study may have taken place during the 1969 “summer of love” and perhaps there was an increase in need by troubled students then, increasing calls during these summer months to the Help Line Telephone Center. There was an increase of 3 calls during the summer months to T.A.N. Teen Help Line.

There were two promotional activities in June. The target audience for these promotions was not necessarily adolescent oriented. One was an article in the AIDS Health Update, the primarily audience being the AIDS health care community. The other was a Health Fair at Latinos/as Contra Sida, the primary audience being HIV/AIDS and
health with Latinos/as. In July there was one promotional activity, a 12-minute television interview with the T.A.N. members on channel 5.

In the month of August there were four promotional activities: A Health Fair at the Hispanic Health Council, A news story on channel 30, and two radio commercials repeated as headliners on two different radio stations. One radio station ran the headliner in Spanish and the other radio station ran it in English. The author was witness to the calls received after the mass media outreach promotional using the radio commercial headliner on the JAMZ 910 a popular R and B music station. The radio headliner targeted adolescent radio listeners and prompted them to call the Teen Help Line. The help line received several calls from adolescents listening to the JAMZ 910 radio spots but, from the author’s observations, the calls were only received immediately after the headliner played. Promotional activities during the month of August represented a small rise in calls.

The author’s research data suggests that the number of calls was related to the number and types of promotional and presentational activities T.A.N. created and implemented. The most effective promotions targeted at-risk adolescents during the community presentations and mass media outreach, such as those in April. The decline in The rate of calls to the T.A.N. Teen Help Line could also have been the result of an absent target population for T.A.N. presentations and promotions during summer vacation.
Judge (1971) reports that calls to Help Line Telephone Center “fell off when students returned to school in September but soon began to rise again” (p.88). The number of calls to the Teen Help Line followed the same calling pattern with a drop in calls during September, October, November and December. In September there were 5 calls to the Teen Help Line, 5 calls in October, no calls in November and only 3 calls in December. There were no presentations or promotions after August. The T.A.N. Teen Help Line ceased its operations and employment of adolescents as listeners in December.

Observational and Thematic Findings-Operations

From the survey data collected by Schondel et al., (1995) the Teen Help Line’s days and hours of operation, Monday through Friday from 5:30 to 7:30 p.m., fits within the norms of help line operation: at least 5 days a week and hours of operation ranging between 1 to 5. The Teen Help Line used only adolescent phone call answerers (PCAs) with adult back-up persons (BUPs) at times when appropriate. The adolescent PCAs only with adult BUPs were the most common type of adolescent phone lines identified.

The Teen Help Line differed from the norm of an adolescent ‘warm line’ because the Help Line listeners were paid for working the two hour shifts. The Teen Help Line had paid employees as staff as well as adolescent volunteers who attended the Peer Educator Training, but were too young to work the phones.

All help lines kept records of phone calls received. The majority of help lines did not have answering machines and only a small percentage would call someone back who left a message on an answering machine. Acosta-Glenn (personal communication March
24, 2000) noticed that several callers stated that they would call back to tell listeners what happened after a referral or other situation. The Teen Help Line used an answering machine and attempted to call back those who left messages. Acosta-Glenn noted that listeners did not record data about where callers found the help line’s phone number, although they wanted to obtain this information to identify which presentations and promotional activities were effective. She explained that there was a need for expanded hours because calls to the help line were made during off-hours and hang-ups were recorded on the answering machine.

The T.A.N. Teen Help Line did not routinely record the gender of callers, although over half of those “warm lines” surveyed did. The Teen Help Line also did not have their data computerized like 32% of those surveyed. Almost three-quarters of “warm lines” surveyed were similar to the Teen Help Line in that they were affiliated with another organization, agency or hospital. Most teen “warm lines” are nonprofit and operate out of space provided through their affiliation with an organization or agency. Funding for the Teen Help Line was provided by foundations and agencies, other “warm lines” rely on organizations, fundraisers, licensing fees, grants and private and public donations.

**Observational and Thematic Findings—Training**

Peer Educator Training for the adolescents consisted of weekly meetings on Saturday from 10:00 a.m. to 12 noon. For the 1999-2000 schedule of T.A.N. Peer Educator Training there were 25 units outlined as topics to be covered before adolescents
could be certified as Help Line listeners. If an adolescent missed one of these topics, they had to make-up the missed material before being certified. The Schondel et al., (1995) survey of all adolescent help lines revealed that volunteers received 20 to over 70 hours of training before answering the phones. The median number of training hours required for adolescent volunteers was in the 40 to 44 hour range. Thus, the Peer Educator Training was above the median at 50 hours of training.

A significant finding was the positive relationship between the length of training time and type of volunteer answering the phone. Schondel et al., (1995) found that hotlines that used only adolescents to answer the phone, like the Teen Help Line, provided considerably more listener training than organizations who used both adults and adolescent volunteers and adults only.

Based on a review of the way the training time was spent by other adolescent “warm lines,” the Peer Educator Training relied on the same small and large group processes, role plays, and lectures provided by guest speakers and staff. The topics outlined for instruction to Peer Educators included the common content of other “warm lines”: active listening skills, problem-solving skills, communication skills, crisis intervention skills, referral sources, record keeping and training on teen suicide, substance abuse, relationships, depression, human sexuality, STDs, physical and emotional abuse. What the Peer Educator Training included that was different from other “warm line” training was: dealing with emotions, career and educational goals, sexual minority youth, cultural diversity, HIV infections and AIDS. There were also recreational activities built
into the training along with a session to gather information and feedback from the adolescents.

The Teen Help Line was a peer listening telephone service where teen listeners helped to clarify callers concerns, made referrals to community resources and provided an empathic ear by just listening to callers concerns. In terms of time Teen Help Line listeners spent with callers, the median was 5 minutes. In speaking with the coordinator of the Teen Help Line service, a number of topics were addressed that should have furthered the “warm lines ” success.

In conversation with Acosta-Glenn (March 24, 2000) she asserted that listeners needed training on protocols for handling help line calls. She knows that adolescents have short attention spans and wants to make sure adolescent centered presentations are given to them. Training should be in a less serious and relaxed way that gets to the point of the information. She said that adolescents are tested for certification by completing the Peer Educator Training sessions and by showing their knowledge of the information through role-play with staff. Adolescents are certified, but it’s not a graded process. Certification means that the adolescents need to know how to find information in the resource book.

Observational and Thematic Findings-Promotional Activities

T.A.N. adolescent program did promotional activities and presentations to get the word out that the Teen Help Line was available to adolescents in the area. The presentations were at health fairs and youth conferences. The promotions were a mix of media: television, radio, newspaper, newsletter and magazine. T.A.N. had flyers and
cards made to promote the help line. T.A.N. used the help line and members’ word of mouth to recruit adolescents. A sustained mix of presentations and promotions targeted the local adolescent audience to increase the number of calls received at the T.A.N. Teen Help Line.

By comparison the Eating Disorders Hotline conducted promotional activities by through articles in the student newspaper, posters, calling cards posted near phones with the Crisis Center phone number on them and word of mouth (Burket et al., 1989). Phone Friend had a cartoon character donated as a spokesperson. They did media relations outreach with the character at schools, in a health calendar and used PSAs on radio and television (“Phone Friend,” 1991). The Kid Call program created a collaborative project with a national television broadcaster as their official media sponsor. The television station designed PSAs for the help line and recruit volunteers. Kid Call did school and health fair distribution of refrigerator magnets and flyers in partnership with regional school districts. They have also ran slides at a movie theater to promote the service (“Kid Call,” 1996; Burket et al., 1989; “Phone Friend,” 1991) wrote that seminars and workshops were used as promotions. “Warm line” affiliation with organizations, hospitals and other agencies helped by providing resources that increased both the hospital’s and the “warm line’s” penetration into the targeted markets serving members of the community (Judge, 1971). Recruitment of volunteers was done through schools, agency settings, church presentations, word of mouth, television, radio and newspaper ads (Schondel et al., 1995).
Acosta-Glenn (personal communication March 24, 2000) stated that the reduction in calls to the Teen Help Line discouraged the group members and that enthusiasm went down when no calls were received. Acosta-Glenn stated that the radio station promotions did not work in terms of the number of increased calls she would have liked. She wanted to find out what mass media worked, and to use that mass media as an outreach source. She stated that Info Line was a good connection for providing feedback on referrals made to the help line and was a valuable resource.

Observational and Thematic Findings-Targets Audience

It is important to know the specific age of the target audiences and the major functions of adolescent telephone services reviewed in order to apply previous experience to the Teen Help Line’s interventions. The targeted audience for the “warm line” services were students at secondary schools (Dolan, 1995), “latchkey” children in the third to sixth grade (“Kid Call,” 1996; “Phone Friend,”1991), junior high and high school students (Boehm et al., 1991), youth aged 17 to 20 years old (Judge, 1971). The Teen Help Line’s target audience was adolescents aged 13 to 24.

The focus of “warm line” telephone services was to provide adolescents with intervention, referral, education, information, prevention, communication and peer to peer listening on topics ranging from: crisis oriented creative listening (Judge, 1971), emergency mental health services (McCarthy et al., 1971), eating disorders (Burket et al, 1989), peer listening service (Boehm et al., 1991; Dolan, 1995), non-emergency help lines for children home alone unsupervised by adults (“Phone Friend,” 1991); and, the
Teen Help Line’s focus on HIV infection, AIDS and STDs education and prevention.

“Warm lines” serve many age groups and provided a large range of services to adolescent callers.

Observational and Thematic Findings-Evaluation

In evaluating the results of what worked for teen “warm lines,” one study identified that giving a student needs assessment survey to students to get their suggestions and opinions was important to the hotline’s success. Applying the Piers-Harris Self-Concept Scales to study student attitudes for future recruitment and training of volunteers also found to be valuable (Dolan, 1995). The author thinks that both of these can contribute to the success of the “warm line.”

School district support of the “warm line” through school events and health fairs, and other resources increased the overall visibility of the “warm line” in the community (“Kid Call,” 1996). A well-organized spokesperson for the “warm line” appeals to adolescents callers and helps promote the “warm line” through school systems, PSAs and media outlets. These on-going media relations programs increase the awareness of the “warm line” and the affiliated hospital (“Phone Friend,” 1991). Boehm et al., (1991) data revealed that peer help lines were an acceptable way to disseminate information to adolescent callers as demonstrated by their consistent use of the program.

The Eating Disorders Hotline staff had callers fill out a questionnaire that used DSM III Diagnostic criteria and Metropolitan Life Weight Tables, did mailings of
information, made telephone follow-up calls for specific questions asked and offered referrals to callers to the affiliated Student Mental Health Services.

The Student Operated Crisis Center developed a Four-Stage model for training in telephone techniques.

Identification of appropriate referral sources was also important. The Center’s outreach methods and promotion had some impact on the increased rates of client contact at the associated Counseling Center and with the caller’s identification that the hotline existence. Further media outreach to the entire university community did not have an effect (McCarthy et al., 1971).

Childrens Hospital of Los Angeles listeners with creative listening skills and the ability to be open and non-judgmental were seen as having the needed requirements (Judge, 1971).

Acosta-Glenn (March 24, 2000) indicated that Peer Educator Training used the adolescents as consultants as part of the group process. She stated that a periodic revaluation of the Peer Educator Training and T.A.N. presentations were based on what the adolescents wanted. Comparing the two age groups, the younger group enjoyed trips to the community activities but outreach was scary for them. She said the older groups’ participation in the help line prepared them for speaking engagements and the youth have seen the Teen Help Line as a job. Acosta-Glenn made new outlines of topics focused on what was important to the adolescents.
Acosta-Glenn (personal communication March 24, 2000) stated that in training 18 adolescents only 3-4 of them has made the certification for help line workers or to do presentations. She stated that there are concerns about welfare reform developments and the impact it will have on adolescents. She pushed college and careers in the Peer Educator Training to help adolescents learn about jobs for themselves and to talk about them on the help line.

**Observational and Thematic Findings-Outcomes**

Acosta-Glenn (personal communication March 24, 2000) reported that prevention services for AIDS were needed she also though there was a lack of appropriate AIDS reporting in the State of Connecticut. ID Family Support Services’ goals, Acosta-Glenn stated, were to link together prevention services, outreach, testing and medical services. She stated that she evaluated the numbers of calls received at the Teen Help Line and concluded that the number of calls received was directly related to the number of promotional activities. Acosta-Glenn had concerns about the number of calls received at the “warm line” and their relationship to the numbers and types of mass media promotions and presentations done by T.A.N. An increase in the number of mass media and outreach presentation would have the effect of increased calls to the Teen Help Line.

Dolan (1995) found that listener volunteers, school counselors and anonymous callers were consistently supportive of the Teen Hot Line. Data established that students working with the help line were motivated to help others in a meaningful way.
The Eating Disorders Hotline found that the phone service made a worthwhile contribution to the university and community in the overall treatment of eating disorders (Burket et al., 1989).

Kid Call was seen as an essential service by the affiliated hospital and the local school districts were very supportive of the project (“Kid Call,” 1996).

PhoneFriend “latchkey” help line succeeded in becoming a prime resource to its local community. The increased awareness of the hospital services through the identification of the help line with the hospital translated into increased use of hospital facilities by the community (“Phone Friend,” 1991).

Boehm et al., survey concluded “that a peer telephone system is an acceptable way of disseminating information to adolescents” (Boehm et al., 1991, p.648).

Limitations of Study

McCarthy et al., identified the difficulty of evaluating paraprofessional telephone services are due to the following: 1. calls were anonymous, 2. follow-up data was practically impossible to gather unless a client called back to inform the student operator of the problem’s outcome (McCarthy et al., 1971, p.528). Referrals could be tracked only if the caller reported the help line was the source of the referral. At the same time he offered perhaps one of the best measures of “warm line” evaluation: “the number of calls received and the student’s judgement of whether the outcome was successful” (McCarthy et al., 1971, p.528). It is also possible to determine the positive or negative impact of the
“warm line” on the target audience based on the number of calls received. An increase in calls received is a good indicator of the program’s success.

The amount of media attention received and promotion activities completed by the “warm line” increased calls to the Teen Help Line, increased listener’s satisfaction and involvement in the services, and increased the public and targeted adolescents awareness of T.A.N. The limitations of this study were that no direct associations could be made between the number of calls received and the number of promotional activities completed.

There was potential bias in data collection in terms the reliability of call categories, both subjective and objective. The data collected by Teen Help Line listeners was, at times, inconsistent or missing on the data entry forms. The method of recording accurate information was of concern for the author in attempting to interpret and report on categories in this thesis.
Conclusions

The problems for health care professionals who provide social and behavioral health care to adolescents are how to develop accessible and acceptable communication channels for the provision of prudent guidance and accurate information to adolescent peers. Health care professionals and hospitals have identified health problems of adolescents in the community and have allied themselves with “warm lines” to provide crisis oriented creative listening peer telephone services. This is done to combat the problems of adolescents concerning: crisis situations such as suicide, abuse and drug abuse; family dynamics, peer relations, eating disorders, mental illness, school problems, sexuality issues including HIV infection, AIDS, and STD; and services for adolescents just to talk. The “warm line” peer to peer telephone listening service provides adolescents with emergency and non-emergency referrals, information, prevention, education and support for adolescents who “just needed to talk to someone.”

The most acceptable communication channels for presentations and promotions to adolescents about the “warm lines” were through school systems, church presentations, agency settings, “word of mouth”, and mass media promotions (PSAs) on television, in the newspapers and on the radio.

Use of well crafted and targeted media programming, promotions and presentations sustains calls to the “warm line,” helps recruit volunteer adolescents and increases the awareness of the “warm line” and affiliated programs in the target communities. Previous research revealed that peer “warm lines” were an acceptable way
of disseminating health promotion and disease prevention information to adolescent callers as demonstrated by adolescents’ continuous use of the system.

The best evaluation of a “warm line’s” success was the numbers of calls received, feedback from callers and the “warm line” operator’s judgement about the outcome of the calls received. An increase in calls received was a good indicator of the program’s success. It is impossible to determine the positive or negative impact of the T.A.N. “warm line” on the target audience based on the utilization of the “warm line” in terms of the number of calls received. The reliability of evaluating categories in terms of the “warm line’s” success is in question with regard to the subjective nature of feedback from callers and the operator’s judgement concerning the outcome of the calls. The objective categories used to evaluate the success for the “warm line” were the number of calls received and a sustained level of calls. Based on the author’s research on the number of calls received at similar “warm lines,” the numbers of calls received at the T.A.N. Teen Help Line indicate that was underutilized.

The T.A.N. Teen Help Line lacked of utilization limited its ability to achieve its major goals: peer to peer education, prevention and intervention for HIV infection, AIDS and STD to the targeted inner city at-risk adolescent population.

**Recommendations Methodology**

The author recommends the development of a health communication plan to sustain rates of calls to the T.A.N. Teen Help Line based on similar models of “warm lines.” The methodology used to create the T.A.N. “warm line” health communication
plan will be based on the CDC Guidelines for Health Education and Risk Reduction Activities ("Guidelines," 1999).

"Consumer-influenced messages and strategies are best achieved by a systematic approach involving research, planning, implementation, evaluation and feedback" ("Guidelines", 1999, p.17). The implementation of a comprehensive health communication campaign as outlined by the CDC could be successful at significantly impacting the behavior of the T.A.N. target adolescents in a positive way. For a comprehensive health communication campaign to be successful several steps must be developed and implemented. There must be a community needs assessment, a developed program design, partnership outreach, theory development, media strategies developed, short-and-long term objectives, staff development and training, adolescent recruitment and training, implementation of the program, media promotions, evaluations and outcome measures and program revisions based on resources, timeframes and program objectives ("Guidelines," 1999).

T.A.N. Teen Help Line needs to develop a health communication campaign to build support for safer behavior by adolescents, provide personal risk reduction, offer education and information to at-risk adolescents, make referrals to adolescents for specific services, listen to adolescent concerns, encourage callers to volunteer and decrease inaccurate information through health promotion and disease prevention. T.A.N. conducted mass media promotions and presentations as part of their health communications activities and outreach to adolescents, but these activities were not sufficient to sustain an increase in calls. Planning and implementing an effective health
communication campaign is essential for successful HIV, AIDS and STD prevention efforts “because many people are uncomfortable discussing subjects that involve sexual issues and behaviors, accessing a hotline for HIV/AIDS/STD information is a viable, anonymous option” (“Guidelines,” 1999, p. 23). The author presents guidelines for making an assessment of an effective health communications campaign based on CDC recommendations and elements identified as effective for “warm lines.”

The selection of appropriate health communication channels for the target audience needs to be an assessment of whether the channels are: 1. likely to reach a significant portion of the target audience, 2. likely to reach them often enough to provide adequate exposure for the message, 3. credible for the target audience, 4. appropriate and accessible for the selected HIV/AIDS message, 5. appropriate for the program purpose, and 6. feasible, given available resources (“Guidelines,” 1999, p 19).

A “warm line” needs measurable short-and-long term program objectives to meet health communication goals. The planning process for T.A.N. health communication campaign should include the following objectives: 1. an increased number of persons (target audience) calling the “warm line” or requesting information or expressing an interest in other ways, 2. an increased number of program participants, volunteers, or requests for T.A.N. activities within the community, 3. an increased number of community leaders who support prevention outreach for HIV/AIDS and believe it is an important issue, 4. an increased number of partners, families, or others engaged in the discussion about HIV/AIDS (“CDC Guidelines,” 1999, p. 17). Measurable objectives are
needed for a comprehensive public information campaign. T.A.N. needs to build into its health communication campaign an evaluation strategy as part of program objectives.

An evaluation of the T.A.N. Teen Help Line involves assessing the amount of media exposure, numbers and kinds of presentations and promotions performed as outreach to the community.

There must also be an evaluation of the program design and development, staffing, adolescent recruitment, program implementation, and program revisions to implement an effective health communication campaign.
Recommendations

The author makes recommendations for T.A.N. program development and design based on a health communications campaign and current research that T.A.N. Teen Help Line can use to sustain the rate of calls. To develop and implement a comprehensive health communication campaign several steps are needed.

There must be an accurate epidemiological assessment of the communities served. Acosta-Glenn (personal communication March 24, 2000) stated how hard it was to gain accurate epidemiological information for T.A.N., but this is needed for present and future planning. Epidemiological assessments provide HIV, AIDS and STD information about the target populations’ behavioral, demographic and ethnic characteristics.

A needs assessment must be conducted to understand the needs and the assets of the community members. Conducting a needs assessments of the targeted adolescent population would serve to establish the needs and priorities of the communities in an attempt to provide the T.A.N. “warm line” with prevention strategies and interventions in response to HIV, AIDS, STD and other adolescent health problems.

T.A.N. should reach out to other service providers and community organizations to establish partnerships. This would help to recruit at-risk adolescents, intensify community relations and offers an organizational connection between presentations and media promotions. Developing partnerships with inner city, disadvantaged adolescents requires overcoming their sometimes pervasive distrust for health agencies and their missions. T.A.N. staff members and adolescents must have cultural competence training
and develop sensitivity and respect for people from cultures who are often times
disenfranchised.

T.A.N. needs to develop a behavior change theory that guides its health
communication campaign based on the desired behavior changes that T.A.N. seeks for
the target population to acquire, maintain or extinguish. The author recommends the
stages of change theory by DiClemente as the theoretical model of behavioral change that
offers the best chance of benefiting “warm line” callers’ at-risk behaviors because
“…calling the hotline may be a critical phase in the move from contemplation of action
or preparation for action to actually taking action in a model of behavior change” (Waters
& Finn, 1995, p.260). The author recommends an organized media outreach program for
T.A.N. designed with standards and guidelines for creating sustained behavioral changes
in callers by providing information and communication in combination with other
prevention strategies. An organized media outreach program includes media strategies
developed through research, short-and-long term objectives, planning, staff development
and training, adolescent recruitment and training, implementation of the program design,
media promotions and presentations and evaluation strategies designed with outcome
measures and program revisions based on feedback of the participants. These goals are
best achieved by setting timeframes and resource allocation.

T.A.N. media strategies and presentations to at-risk adolescents did not sustain an
increase in calls to the Teen Help Line and the T.A.N. “warm line” ceased to operate.
Developing, planning and implementing an effective health communication campaign
would be essential for the Teen Help Line to be successful at re-establishing its
prevention efforts. T.A.N. media strategies included three types of communication channels: 1. mass media, 2. interpersonal, and, 3. community. A review of each communication channel would help assure the best selection and use of appropriate channels in future T.A.N. media strategies.

The mass media channels that T.A.N. used were radio (PSA), stories on television, newspaper articles, newsletters ads, magazine articles and ads, flyers and printed cards. The interpersonal channels were the T.A.N. adolescents on the “warm line” and the T.A.N. Adolescent Speakers Bureau. T.A.N. Peer Educator Training also had staff and guest speakers. Community channels for T.A.N. were health fairs in community settings and a youth conference. Assessing the best traits of each channel and reinforcing the message through an appropriate mix of multiple channels and was the goal of the T.A.N. staff.

The selection of the appropriate communication channels to reach the T.A.N. target audience must be made through an assessment of whether the channels are likely to reach a significant portion of the target audience. T.A.N. messages were rated on their ability to reach the target audience by observing who was at T.A.N. presentations in the community and through the media outlet’s assessment of the demographic profile of the viewers, readers or listeners. T.A.N. should assess whether the messages are likely to reach the target audience often enough to provide adequate exposure. The author identified two times during the health communication campaign that T.A.N. created and sustained multiple media presentations and promotions. In April there was a mix of mass media promotions and presentations totaling four. The two mass media channels were a
television show on a local channel that gave an 8-minute interview and a local community magazine that ran a free ad. The two community channels were a youth conference with 100 youth at an addiction recovery meeting and an AIDS health fair with 60 youth. There was a spike in calls recorded in May, which may have been a result of the youth targeted community events in April. In August there were similar multiple mass media presentations and promotions as in April. In August there was a total of four presentations and promotions. There were a community health fair at the Hispanic Health Council with 100 people and three mass media promotions; a news story on a local television station and a sustained radio PSA promotion on two different radio stations and in two languages. The August multiple media events failed to increase the rate of calls any significant degree because they may have not targeted the youth who would have called the T.A.N. Teen Help Line.

The presentations and promotional activities during the month of April directly targeted the greatest number of at-risk adolescent with an audiences of 160 youth who have the most interest in T.A.N. membership and in the Teen Help Line. In August the multiple mass media promotions did not capture the attention of the target adolescent prompting them to call the T.A.N. Teen Help Line. One reason for low success of the August activities may be that adolescents were on school vacation and distracted with outdoor activities. Also the health fair audience was more adults than adolescents. The news story, although targeted to the local audience did not focus on the adolescent population. The two radio stations running PSAs as headliners both in Spanish and
English were the most targeted mass media efforts in August but failed to prompt as many calls as expected as a result of the targeted mass media efforts.

The credibility of the message and the messenger are important issues in designing an organized media outreach program for a health communication campaign. T.A.N. Teen Help Line adolescents are a credible messenger to adolescent callers, and peer to peer communication offers a credible channel to convey health promotion and disease prevention messages to adolescent callers.

The T.A.N. Teen Help Line peer to peer communication method is appropriate for adolescents who call seeking select adolescent health messages, information, referral and conversation from adolescents manning the phones. T.A.N. Teen Help Line accessibility for adolescent callers is questionable because of the limited hours of service. Availability for two hours on weekday evenings in the evening (5:30 to 7:30 p.m.) was extremely limited for adolescent callers. Weekend and after-hour callers could leave a message on the T.A.N. answering machine for a return call.

T.A.N. mass media promotions and presentations were appropriate for at-risk adolescents, given the program purpose of providing current and accurate health promotion and disease prevention information. The T.A.N. presentation and promotions provided accessible information for the targeted adolescent age groups calling the “warm line” and for recruitment into the Peer Educator Training. T.A.N. efforts to maintain the Teen Help Line and Peer Educator Training, given the available resources were due to the
T.A.N. staff and adolescents working together to identify, prioritize, plan, design and implement the Teen Help Line interventions.

The “warm line” needs clear and explicit measurable short-and-long term program objectives. The T.A.N. program design and health communication campaign needs to be assessed by the following objectives:

1. An increased number of adolescents in the target audience calling the Teen Help Line or requesting information or expressing interest in some way. The peak in phone calls to the Teen Help Line was the 23 calls in March, the first month of operation. An initial novelty effect and preprogram publicity resulted in this high number of calls. Acosta-Glenn (personal communication March 24, 2000) asserted that to overcome the deficiencies in the number of adolescents calling the help line, a number of presentations and promotions should have occurred. The decreased numbers of calls in the later months of the Teen Help Line can be attributed to adolescents being on summer vacation and the lack of sustained media and presentations directed towards the T.A.N. target audience.

2. An increased number of program participants, volunteers, or requests for T.A.N. activities within the community. T.A.N. attributed an increase of 13 additional adolescent volunteers since August 1999 to presentations and promotional outreach. The Teen Help Line received inquiries from callers about volunteering for the Peer Educator Training. T.A.N. sought out community organizations to be part of their health fairs and community activities. The T.A.N. health communication campaign needs to build
networks with organizations, schools and agencies that target at-risk adolescents.

Establishing a partnership with local media outlets such as newspapers, health newsletters and radio and television stations would have the effect of increasing community awareness and also requests for T.A.N. activities at community events.

3. An increased number of community leaders who support prevention outreach for HIV/AIDS and believe it is important. T.A.N. needs to build partnerships with community members who are part of the HIV/AIDS prevention networks. Working with people who are providing, or support, HIV/AIDS information and interventions increases awareness of key people and programs that serve the T.A.N. target population.

4. An increase in families and collaborations with others engaged in the discussion about HIV/AIDS. Providing a forum for discussions concerning HIV/AIDS information and interventions for adolescents is necessary to engage community concerns and objectives for the health communication campaign. The families of T.A.N. adolescents are a secondary audience that need a voice in their child’s and other adolescents’ HIV/AIDS education, training and involvement in T.A.N. programming. T.A.N. should increase the number of people involved in their media outreach, health promotions and HIV/AIDS interventions who can provide their expertise and experience with the community, target audience and health communication campaigns.

Measurable objectives are needed for a comprehensive health communication campaign. T.A.N. needs to build into its health communication campaign an evaluation strategy as part of its short-and-long term program objectives. An assessment of media
exposure needs to be evaluated to determine whether T.A.N. is meeting its program objectives:

1. An assessment of T.A.N. presentation and promotions in terms of quantity and quality is needed to evaluate if the media strategies are benefiting the health communication campaign.

2. An assessment of T.A.N. media exposure needs to be based on the quantity of calls received. T.A.N. kept track of how much coverage they received as a result of their media efforts through clippings of print media, copies of television programs for review and how many and types of people came to the presentations. Staff recorded placement of ads, articles, stories or PSA coverage and where presentations were performed.

3. Media planning by T.A.N. staff placed mass media and presentations in relationship to the target audience’s media habits. One example of T.A.N. Teen Help Line listener’s knowledge of the target audience’s media habits was by requesting the PSA headliner during help line hours to increase calls from those at-risk adolescents listening to the radio.

4. T.A.N. needs to assess the content of media exposure for its ability to attract accurate reporting and favorable attention. The T.A.N. health communication campaign received media exposure that was accurate and well reported giving favorable exposure to the Teen Help Line. An example of the accurate reporting and favorable media attention T.A.N. received were several articles in local daily papers. If T.A.N. did media outreach for articles or ads in local African American or Latino newspapers favorable media
attention and credibility for the “warm line” could be created within those communities. There were no reports by T.A.N. that media exposures contained incomplete, misleading or negative information.

5. Feedback from the target population, media outlets and decision-makers in the community in response to media exposures are important to the evaluation process. Objective and tangible responses are needed to gage the effect of media exposures on the target population and communities served for reevaluating the program objectives and media outreaches.

What the author learned from the review of the literature, research, and internship with adolescents from Teen Against Negligence will now be applied to make recommendations for starting with the same group again to create the T.A.N. “warm line.” Many adolescents know someone with HIV/AIDS, but few think that HIV/AIDS is as an important issue. Health care providers want to change adolescents’ sexual risk taking behaviors but HIV/AIDS/STD goes unnoticed in adolescents until they seek medical attention. T.A.N. adolescents wanted to start the Teen Help Line to change adolescents’ sexual risk taking behaviors. This involves an increase in adolescents’ HIV/AIDS/STD knowledge and the establishment of peer norms that decrease risk taking sexual behavior and increase adolescents’ skills for effective communication in sexually risky situations. The psychosocial and cultural dynamics that impact adolescent’ behaviors are on an interpersonal level and they do not link sexuality with life-threatening diseases. Lack of appropriate preventive health behaviors propels the HIV/AIDS/STD epidemic. Changing adolescents’ sexual behaviors is a formidable challenge. T.A.N. is
trying to target two populations of adolescents: at-risk adolescents and HIV infected/affected adolescents. The Teen Help Line targets the at-risk adolescent with peer to peer communications. The Peer Educator Training targets the HIV infected and affected adolescents with a support group, and training for direct outreach. To effectively meet the needs of the different adolescent populations in terms of outreach and support T.A.N. needs a narrow and a broad approach in targeting the adolescents T.A.N. seeks to serve.

The T.A.N peer to peer “warm line” focuses on HIV/AIDS/STD and other psychological and behavioral health problems of at-risk adolescents. T.A.N. HIV infected and affected listeners know the risk factors from their life experiences and from the Peer Educator Training. T.A.N. adolescents have established (by the topics they chose to include in the Peer Educator Training) that they would like to provide peer to peer outreach to adolescents other than themselves. Addressing these broader concerns of at-risk adolescents’ offers more choices of topics and more media outlets for the T.A.N. group. It was thought that the broader media outreach and more topics of adolescent concern would increase calls to the “warm line.” But it was discovered that it might have been the targeted media outreach to at-risk adolescents that increased calls to the “warm Line.” The conclusion is that targeted audience interventions are needed to meet the need of T.A.N. listeners and the specific population of at-risk adolescents T.A.N. seeks to serve. These presentations and media outreach efforts need to be set in a theoretical model, and must be culturally sensitive and developmentally appropriate for the target audience. T.A.N. peer to peer “warm line” offers social support, development of peer
norms and communication to counter high-risk behavior. T.A.N. should create services for targeted at-risk adolescents that identify their serostatus and recruits and trains them for the Peer Educator Training and Speakers Bureau. There are several population sources for serostatus identification, recruitment and training: at-risk adolescents, runaways, substance abusers, drop outs, family members and peers of HIV infected adolescents.

Media promotions and presentations should use school systems and add T.A.N. Speakers Bureau for presentations for outreach that support the schools HIV/AIDS prevention curriculum. T.A.N. use of presentations and flyers at community settings, health clinics and health fairs increased community knowledge of their programs and targeted presentations increased calls to the “warm line.” A media specialist is needed at T.A.N. to concentrate and intensify the media outreach programs’ use of television, radio, and print media to reach the targeted audiences.

The Peer Educator Training is basically a support group for HIV infected and affected adolescents and has a narrower focus for media outreach and presentation. The Peer Educator Training provides adolescents with accurate information about HIV/AIDS/STD. The group relies on peer social modeling from the older group members to the younger ones. There should be more active learning to increase their self-efficacy skills in at-risk situations and more social supports to develop the peer norms that are used on the “warm line.” For the Peer Educator Training, topics should focus on the psychosocial, interpersonal, developmental, cultural and environmental roles involved in adolescent decision-making and provide skills for changing behavior. At T.A.N. there is a
lack of effective communication skills concerning sexuality and how to negotiate with others concerning the perceived peer norm of denial of seropositive status.

Narrowly focused media outreach to the two target audiences (HIV infected/affected adolescents and at-risk adolescents) using appropriately targeted media and presentation strategies will enhance the numbers of adolescents entering the Peer Educator Training and calling the T.A.N. Teen Help Line. It is also important to have a broad spectrum of media outreach, to include the community members and to gain public support.
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### Teens Against Negligence Teen Help Line “listeners” Telephone Log

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Date</th>
<th>Time of Call</th>
<th>Call End Time</th>
<th>OUTCOME</th>
<th>Notas</th>
</tr>
</thead>
</table>

#### KEY

- **A**buse
- **AIDS**
- **Alcohol**
- **Career**
- **Depression**
- **Divorce**
- **Drugs**
- **Education**
- **Employment**
- **Family Life**
- **Future**
- **Gangs**
- **Grief**
- **Gun/Weapons**
- **Homelessness**
- **Homoerosexuality**
- **Life**
- **Medication**
- **Money**
- **Nutrition**
- **Processes**
- **Peer Pressure**
- **Pregnancy**
- **Sex**
- **STD’s**
- **Suicide**
- **-specific**
- **-detail**
- **-accessibility**
- **-privacy**

#### OUTCOME KEY

- Listen: **L**
- Information: **I**
- Referral: **R**