2014 Teen Talk Evaluation

Evaluation of comprehensive sexual education programs funded through the Personal Responsibility Education Program (PREP) grant to the Connecticut Department of Public Health and developed and implemented by Planned Parenthood of Southern New England (PPSNE).

Interim Report

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2014 Teen Talk Evaluation:
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Executive Summary

In 2011, the State of Connecticut Department of Public Health (DPH) received the State Personal Responsibility and Education Program (PREP) grant from the federal Family and Youth Services Bureau (FYSB) to provide comprehensive sexual education to youth living in foster care and in geographic areas with high rates of teenage pregnancy. As part of Connecticut's State PREP grant, Planned Parenthood of Southern New England (PPSNE) implemented *Teen Talk,* a 10-hour program consisting of four workshops designed to educate young people on sexually transmitted infections, contraception, abstinence, reproductive health, relationships, and access to reproductive health services.

During the PREP fiscal year (FY) 2013/14, PPSNE held 17 *Teen Talk* workshop series in communities throughout Connecticut. To ensure program implementation with fidelity, PPSNE monitored each series via observer- or facilitator-completed fidelity checklists. The results of fidelity monitoring showed that:

- most *Teen Talk* activities were delivered as intended in most workshop series;
- participants in most workshops appeared to be interested and engaged;
- over half of workshops had a "rushed" feel; and
- at least one activity in each series was either shifted from one workshop to the next or omitted altogether.

Of the 17 workshop series that were implemented during the PREP FY 2013/14, 5 were provided to youth residing in congregate care programs operated by Connecticut's child welfare system, one to young adult inpatients in Connecticut's Central Valley Hospital (CVH), and 11 to youth living in communities with high rates of teenage pregnancy and birth. Altogether, 270 youth participated:

- 212 (79%) joined *Teen Talk* on the first of day of a *Teen Talk* series;
- 63 (23%) attended only one of four workshop in a series;
- 36 (13%) participated in PPSNE educational programs prior to the PREP FY 2013/14; and
- 8 (3%) attended two workshop series during the PREP FY 2013/14.

Among the 262 unique participants (those who attended no more than one workshop series during the PREP FY 2013/14), there were 160 (61%) young women and 98 (37%) young men (4 youth didn't specify gender or identified as transgendered). A majority of participants were youth of color: 125 (48%) identified as Black/African American, 57 (22%) as Latino/a, 43 (16%) as White/European American, and 37 (14%) as another ethnic background. The average age of participating youth was 16.4, with a range from 13 to 23 years old.

Among the 212 participants who joined *Teen Talk* on the first day of a series, 144 attended at least three *Teen Talk* workshops. This is to say that 68% participants attended 75% of the program. Although the 68% rate falls short of the FYSB goal of having at least 80% of participants attend at least 75% of the program, it signifies a relatively high level of retention, especially considering the fact that *Teen Talk* is a community-based program and that participants are not incentivized to attend workshops.

Participants' experiences in *Teen Talk* were assessed via entry and exit surveys: entry surveys were completed at the beginning of the first workshop in each series and exit surveys were completed at the

end of the fourth workshop. A total of 178 entry surveys and 98 matched entry and exit surveys were completed as part of this process. Participants reported on exit surveys that:

- they had a chance to ask questions all or most of the time (*n* = 81, 83% youth);
- discussions or activities helped them learn all or most of the time (*n* = 86, 88% youth);
- material presented was clear all or most of the time (*n* = 85, 87% youth); and
- they felt interested in program sessions all or most of the time (*n* = 81, 83% youth).

Additionally, participants reported that *Teen Talk* positively influenced their educational intentions and their ability to form prosocial friendships and resist peer pressure. In particular, youth indicated that, as a result of *Teen Talk*, they were more likely to:

- talk about things that really matter with a parent or guardian (*n* = 66, 67% youth);
- care about doing well in school (*n* = 64, 65% youth);
- resist peer pressure (*n* = 73, 74% youth); and
- form prosocial friendships (*n* = 59, 60% youth).

Consistent with perceptions of *Teen Talk*'s positive influence on adulthood preparation, exit surveys suggest that the program was perceived to have a positive influence on sexual risk taking. Youth reported that, as a result of *Teen Talk*, they were more likely to:

- use a condom (*n* = 66 out of 84, 78% youth);
- use birth control (*n* = 61 out of 84, 73% youth); and
- abstain from sex (*n* = 34 out of 98, 35% youth).

It is important to note that participants' perceptions of *Teen Talk* and its influence on their preparation for adulthood and sexual risk taking are similar to the perceptions of youth who participated in PREP-funded evidence-based programs.

Lastly, comparisons over time in participants' intentions to have sex show that most youth (64/98) did not experience a change over the course of *Teen Talk.* That being said, a small but significant number of sexually-experienced youth (6/54) switched from intending to have sex on entry to not intending to have sex on exit.

On the whole, preliminary evaluation results show that 1) *Teen Talk* is generally implemented as intended; 2) the target audience of youth in foster care and youth in geographic areas with high rates of teenage pregnancy and birth is being reached; 3) the retention rate among attendees of the first workshop in a series is acceptable; 4) participants are satisfied with *Teen Talk* and perceive it to be a positive influence on their wellbeing and on their engagement in safe sex behaviors. The results also point to the areas of growth: 1) addressing the number of activities relative to workshop length, 2) increasing attendance at *Teen Talk* workshops, 3) increasing the retention rate across workshops in a series, 4) increasing the number of participants who complete both an entry and an exit survey, and 5) modifying the delivery of *Teen Talk* to youth with involvement in the child welfare system.

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Introduction

Federal funding for sex education has long been driven by not only public health concerns but also social trends and value positions. Starting with the Reagan Administration in the 1980s and continuing through the George W. Bush era, the federal government funded only those educational programs that withheld information on contraception and other safe sex practices. Federal funding for abstinence-only programs continued and even expanded between 1996 and 2006, despite the growing evidence of their ineffectiveness in delaying sexual initiation and, ultimately, reducing sexually transmitted infections (STIs) and pregnancy rates among youth (Collins, Alagiri, Summer, & Morin, 2002; Kirby, 2008; SEICUS, n.d). It is only during the Obama Administration that the federal government reversed its course and, for the first time in 30 years, allocated funds for comprehensive sex education.

Starting in the federal fiscal year 2010, one of the new streams of funding for sexual education was the Personal Responsibility Education Program (PREP). Created as one of many provisions of the Patient Protection and Affordable Care Act of 2010 and administered jointly by the Administration on Children, Youth and Families and the Family and Youth Services Bureau (FYSB), PREP seeks to provide medically accurate sex education in order to prevent pregnancy and STIs among youth ages 10 to 19, especially targeting those who are homeless; youth living in foster care, rural areas, or geographic areas with high teen birth rates; or members of ethnic minority groups. Under the state-grant portion of PREP, FYSB awards grants to State agencies to "replicate effective, evidence-based program models or substantially incorporate elements of projects that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth" (FYSB, 2013, ¶3). In addition to educating young people on abstinence and contraception, PREP seeks to provide adulthood preparation through activities that address healthy relationships, positive adolescent development, financial literacy, parent-child communication skills, and life skills such as goal-setting, decision making, negotiation, communication, interpersonal skills, and stress management.

In Connecticut, the State PREP grant was awarded to the State of Connecticut Department of Public Health (DPH) to provide sex education to youth living in foster care. The focus of the State PREP project was subsequently expanded to include young people living in geographic areas with high teenage birth rates. DPH partnered with the State of Connecticut Department of Children and Families (DCF), Connecticut State Department of Education (CSDE), the Department of Mental Health and Addiction Services (DMHAS), Planned Parenthood of Southern New England, Inc. (PPSNE), and True Colors, Inc. to develop a state plan to offer programs based on *Teen Talk*, *Streetwise to Sex-wise*, *Making Proud Choices!*, *Be Proud! Be Responsible!*, and *Reducing the Risk* curricula. This report presents interim findings from an evaluation of *Teen Talk*, a comprehensive sex education program developed by PPSNE and implemented in communities throughout Connecticut during the PREP fiscal year (FY) 2013/14. In particular, included in the report are the preliminary findings on the process evaluation, evaluation of the evaluation, and the outcome evaluation. Accordingly, the report contains the following five sections:

1) *Data Sources* – description of data sources—fidelity checklists, attendance logs, and surveys—that were analyzed as part of the evaluation;
2) *Teen Talk* – description of the curriculum as originally developed by PPSNE and as implemented during the PREP FY 2013/14;
3) *Process Evaluation Findings* – discussion of fidelity monitoring, attendance at *Teen Talk* workshops, participants' background characteristics, and participants' perceptions of the program;

4) *Evaluation of the Evaluation* – an overview of successes and challenges with collecting entry and exit surveys from *Teen Talk* participants and with tracking attendance at *Teen Talk* workshops;
5) *Outcome Evaluation Findings* – overview of preliminary outcomes findings, including knowledge and attitudes after participation in *Teen Talk* and changes over the course of *Teen Talk* in intentions to have sexual intercourse.

Data Sources

Sources of information for this report include the following:

1) *Fidelity monitoring checklists* – PPSNE educators and observers are tasked with completing a fidelity monitoring checklist following each series of *Teen Talk* workshops. The checklists were created by *Teen Talk* developers and include a list of activities that are to be covered during each workshop series.
2) *Teen Talk attendance records* – PPSNE educators track attendance for all *Teen Talk* participants, regardless of when they first start coming to *Teen Talk* and how many workshops they choose to attend. Following each workshop series, educators transfer attendance records, along with participants' ID codes and demographic background information (i.e., gender, age, grade, ethnicity), into an Excel log sheet, which is then shared with the evaluation team. It is worth noting that participant ID codes are created by young people based on instructions provided by PPSNE educators. To allow for matching over time and across data sources, the same code is used for each participant for all data sources (i.e., attendance, entry survey, exit survey).
3) *"Enhanced" PREP Performance Monitoring surveys*. Prior to the first workshop in a *Teen Talk* series, participating youth are asked to complete an entry survey; similarly, upon completing the final workshop in a series, youth are asked to complete an exit survey. These surveys are self-administered paper-and-pencil questionnaires developed by Mathematica Policy Research for the purpose of the national PREP evaluation, which includes all PREP grantee subawardees. These surveys are referred to as the PREP Performance Measures. The entry survey includes questions about participants' demographic background characteristics, sexual experience, intent to have sex, and perceptions of preparedness for adulthood. The exit survey includes questions about participants' perceptions of program effectiveness regarding sexual behaviors and adulthood preparation, as well as a question about participants' intent to have sex. For the purpose of the *Teen Talk* evaluation, PREP Performance Monitoring surveys were expanded to include measures of motivation to have sex; sense of stigma and shame associated with STIs; hope and optimism about one's future; knowledge of contraception; and self-efficacy to say 'no' to sex (if one is not ready to have sex) and to insist on using contraception.

Teen Talk

Teen Talk was created in 2007 out of a desire to reduce teen births and STIs among youth. Much of the original input for *Teen Talk* came from PPSNE's peer educators during a discussion on how to best reach young people regarding healthy sexuality. With peer educators' feedback as a starting point, the PPSNE Education and Training Department assembled a team of professionals with varied backgrounds—adolescent sexual behavior, curriculum design, community culture, and sex/HIV education—to design an effective sex education program. The team reviewed local and state data on young people's sexual behavior, pregnancy, and STI rates; consulted Douglas Kirby's (2007) comprehensive review of research findings on programs aimed at reducing teen pregnancy and STIs; conducted informal focus groups with

youth; and held interviews with key adult stakeholders. Information gathered through this process lead to an identification of a health goal and the development of a Behavior-Determinant-Intervention logic model (Kirby, 2004; Appendix A). Additionally, the team created a program outline and developed educational activities that are consistent with community values and resources. The activities were pilot-tested and revised based on feedback from educators, participants, and community stakeholders. What is more, peer educators reviewed the program outline and provided suggestions for revisions. In particular, they emphasized the importance of including reproductive health care and family planning services in the *Teen Talk* curriculum.

In 2008, PPSNE and John Snow Inc. (JSI) began discussion with the Centers for Disease Control and Prevention (CDC) about performing the level of research necessary to move *Teen Talk* into the U.S. Department of Health and Human Services list of effective programs. In March 2009, the CDC invited PPSNE and JSI staff to their Atlanta offices to present the *Teen Talk* curriculum and to discuss how to support an evaluation of the program that could be published in a peer-reviewed journal. Following PPSNE's presentation to the CDC, PPSNE's Education and Training department staff members were invited by JSI/NETCAPP and the Healthy Teen Network to conduct a rigorous, two day review of *Teen Talk* using Kirby's *Tool to Assess the Characteristics of Effective Sex Ed and STD/HIV Education Programs*. This tool outlines the 17 characteristics needed to develop an effective sex education program in a community. After the review, *Teen Talk* received the "promising program" designation.

Theoretical Background

The Health Belief Model (HBM), one of the first and most widely recognized models in health education and health promotion, provides a theoretical framework for *Teen Talk* (National Cancer Institute, 2003). The HBM conceptualizes health-related behavior as a function of six key factors: 1) perceived susceptibility to a condition or disease; 2) perceived severity of the consequences; 3) perceived benefits of health-related action; 4) perceived barriers to taking health-related action; 5) cues to action (internal cues such as a symptom or external cues such as a reminder about doctor's appointment); and 6) self-efficacy (confidence in one's ability to perform a new health behavior). So, for example, if a young man believes that he is at risk for HIV and that condoms are effective at preventing HIV, if he is able to access condoms and if he knows that he can use them comfortably and with confidence, he will be more likely to use them. If, however, he thinks of condoms as uncomfortable, difficult to access, and ineffective, he will be less likely to use them.

The application of the HBM in *Teen Talk* has led to a number of activities that address perceived barriers, highlight benefits, and boost participants' self-efficacy in using contraception. What follows are two illustrative examples:

1) *Condom Demonstration and Practice*: To dispel myths about condoms and to acknowledge that condom use can sometimes be challenging, *Teen Talk* allows for an open-ended discussion of issues that need to be considered when using condoms. In the course of the discussion, educators encourage participants to come up with solutions on their own terms. This helps overcome perceived barriers to condom use. Additionally, allowing participants to practice with an actual condom enhances their skills and generates a sense of self-efficacy.
2) *Health Center Tour:* The third *Teen Talk* workshop includes a tour of a reproductive health center. During that tour, participants meet health center staff and have a safe and positive experience in

the center. The tour and the interaction with staff reinforce the belief that participants can expect a positive experience by taking a recommended action such as going to a health center for testing in order to avoid a negative health condition such as an STI. This reinforcement is the backbone of the HBM.

Curriculum

Teen Talk consists of four 2.5-hour workshops that are, per original design, held on four consecutive evenings. The workshops cover the following topics:

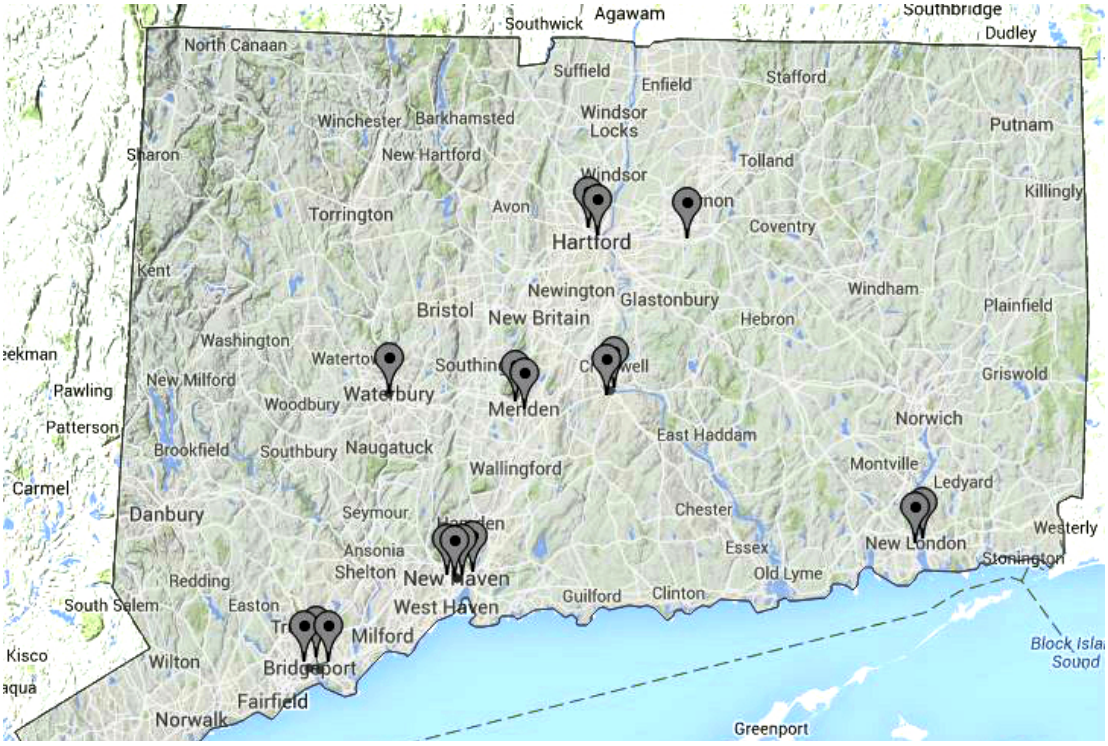
1) anatomy and reproductive health;
2) birth control methods, including abstinence;
3) sexually transmitted diseases, including HIV/AIDS; and
4) relationships, including sexual decision-making.

During the third workshop participants receive a tour of a health center. Activities in the fourth workshop are designed to reinforce the importance of communicating about sexuality with peers and with trusted adults. These conversations help create a new social norm that talking about safer sex and reproductive health is accepted and healthy. Upon completion of all four workshops, participants receive a voucher for reproductive health care and family planning services (including STD testing and treatment), a gynecological exam, and one year of free contraceptive supplies.

PREP-Funded Implementation of Teen Talk

During the PREP FY 2013/14, 17 *Teen Talk* series were held in PPSNE health care centers and community sites situated in large and mid-sized cities with a higher-than-the-state-average rate of teen birth (Figure 1). Workshops were delivered by PPSNE health educators, all of whom were trained on delivering sex education with fidelity to the curriculum.

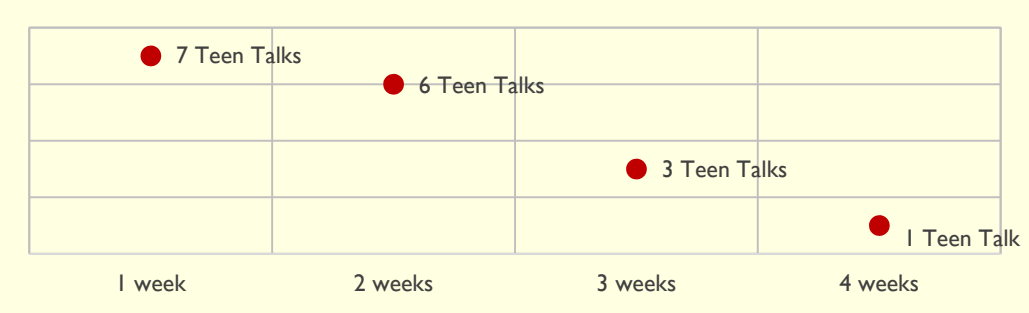
Figure 1. *Teen Talk Locations*



Teen Talk participants during the PREP FY 2013/14 were residents of communities with high rates of teenage pregnancy, residents of adolescent congregate care programs operated by Connecticut Department of Children and Families (DCF), and inpatients in a psychiatric hospital. Community-based youth were recruited to attend *Teen Talk* through STARs, young people who are employed by PPSNE to provide peer education and to promote utilization of sex education programs and reproductive health services. Other sources of information about *Teen Talk* included friends and relatives, school guidance counselors, school nurses, and, in a few instances, parents. Residents of congregate care programs came to *Teen Talk* at the urging of their caseworkers and adolescent program staff. In a number of instances, adolescent program staff brought youth to *Teen Talk* in order to fulfill the life skills education requirement set by the state's child welfare system.

Although *Teen Talk* was originally designed to be held over the course of four consecutive days, during the PREP FY 2013/14 implementation the program was "stretched out" over the course of two, three, and, in some instances, four weeks (Figure 2).

Figure 2. *Teen Talk Delivery Format*



Extending the length of time over which *Teen Talk* workshops were delivered was a function of weather-related cancellations, attempts to accommodate the schedules of adolescent congregate care programs, and attempts to accommodate participants' needs (by offering, for example, make-up sessions). It is unclear whether and how differences in delivery format might influence acquisition and retention of knowledge, changes in attitudes and beliefs, and changes in intentions.

Process Evaluation Findings

Fidelity Monitoring

The fidelity monitoring protocol during the PREP fiscal year 2013/14 included 1) structured observation by fellow educators and by PPSNE STARs, using the *Teen Talk* fidelity checklist as an observation guide; 2) completion of fidelity checklists by workshop facilitators; and 3) unstructured observation by members of the evaluation team. One fidelity checklist was completed–by either an observer or a workshop facilitator–for each workshop series. What is more, each educator's rendition of *Teen Talk* was observed at least once.[1] An analysis of completed fidelity checklists shows that:

[1] One educator was not observed during the PREP FY 2013/14. However, this educator co-facilitated his first workshop series with another PPSNE educator.

1) most *Teen Talk* activities were delivered as intended in most workshop series;[2]
2) participants in 13 out of 16[3] workshop series were described as interested and engaged;[4]
3) 36 out of 64 workshops across the 16 workshop series were rated as "feeling rushed"; and
4) activities were either shifted from one workshop to the next or omitted altogether in each of the 16 workshop series.

Across the board, it appears that workshop facilitators found themselves not having enough time to complete the activities. Reasons for this were varied and included the following:

1) participants coming to workshops or being brought in by caseworkers 15 to 40 minutes late;
2) entry and exit surveys taking away 15 to 30 minutes from the first and the last workshop in each series;
3) participants asking many relevant questions; and
4) facilitators experiencing behavior management difficulties in workshop series for youth with DCF involvement.

Ultimately, a possible reason for the relative shortage of time might simply be too many activities for the allotted period of 2.5 hours.

Workshop facilitators used several strategies to address time shortages. These included 1) shifting activities from one workshop to the next; 2) omitting activities altogether;[5] 3) reducing the amount of time devoted to processing activities and discussing issues; 4) partially covering or omitting aspects of activities;[6] and 5) modifying activities.[7] Table 1 presents the pattern of activity shifting and activity

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[2] Three out of 16 workshop series went off track to a smaller or greater extent. In the Waterbury 7/22/14 series for DCF youth, behavior management was a challenge; the group "went out of control" early in workshop 3 and the facilitator was unable to complete workshop 4 activities and do the clinic tour until after the exit surveys had been administered. The tour was provided to these participants about a month after the last workshop in the series.

In the New Haven 8/18/14 series, the facilitator was unable to complete workshop 4 activities because too much time was spent on the initial activities (participants were interested and engaged as rated by the facilitator and, independently, by a member of the evaluation team). The facilitator worked with a supervisor to help facilitate discussions so as to keep *Teen Talk* on track.

In the Bridgeport 9/22/14 series, the facilitator was unable to complete the clinic tour because patients were being seen at the time of the workshop. Five other activities were not completed during this series (participants were interested and engaged as rated by the facilitator and, independently, by a member of the evaluation team). Notably, most participants in the New Haven 8/18/14 and Bridgeport 9/22/14 series were newly-recruited PPSNE STARs, who subsequently received additional sexuality training as part of preparation for peer education.

[3] One of 16 workshop series was substantially modified as it was delivered to inpatients in a psychiatric hospital. As such, this series was not included in the analysis of fidelity monitoring and survey data.

[4] Facilitators and observers of three workshop series for DCF youth (Waterbury 7/22/14, Middletown 6/13/14, and Meriden 7/28/14) indicated on fidelity monitoring sheets that some or none of the participants were interested. In workshop 3 of the New London 5/15/14 series, the facilitator reported that some but not all participants were interested.

[5] The Sexual Response activity from the first workshop was omitted in 5/16 workshop series and partially completed in 4/16 series. The Behavior Risk Continuum activity from the third workshop was omitted in 4/16 series and partially completed in 2/16 series.

[6] As an example of partially covering or omitting aspects of activities, consider the fact that PPSNE services were not discussed at every specified juncture in 9/16 workshop series. In 4/16 series, the role of trusted adults in addressing relationship difficulties was not discussed at all.

[7] One example of modifying an activity is holding a group discussion about an issue instead of having participants write on newsprint, discuss in small groups, and then bring to the large group.

omission. What stands out is that at least one workshop 4 (healthy relationships) activity was omitted in 13 out of 16 series. Additionally, at least one of the 36 *Teen Talk* activities was omitted in 14 out of 16 series. Lastly, clinic tours were not conducted in 3 out of 16 series.

Attendance

During the PREP FY 2013/14, there were 270 participants across 17 workshop series. Of these, 156 (57.8%) attended 75% of the curriculum; 63 (23%) attended one workshop only; and, 8(3%) attended at least one workshop in two different workshop series. Notably, 36 (13%) youth participated in PPSNE educational programs prior to the PREP FY 2013/14.

Two hundred twelve (212) participants joined *Teen Talk* on the first day of a given workshop series. Of these, 27 (13%) did not return to *Teen Talk* after the first workshop. In contrast, 144 (68%) attended at least 3 workshops. Although the 68% rate falls short of the FYSB goal of having at least 80% of participants attend at least 75% of the program, it presents a relatively high rate of retention considering that *Teen Talk* is a community-based program and considering that participants are not incentivized to complete the program.

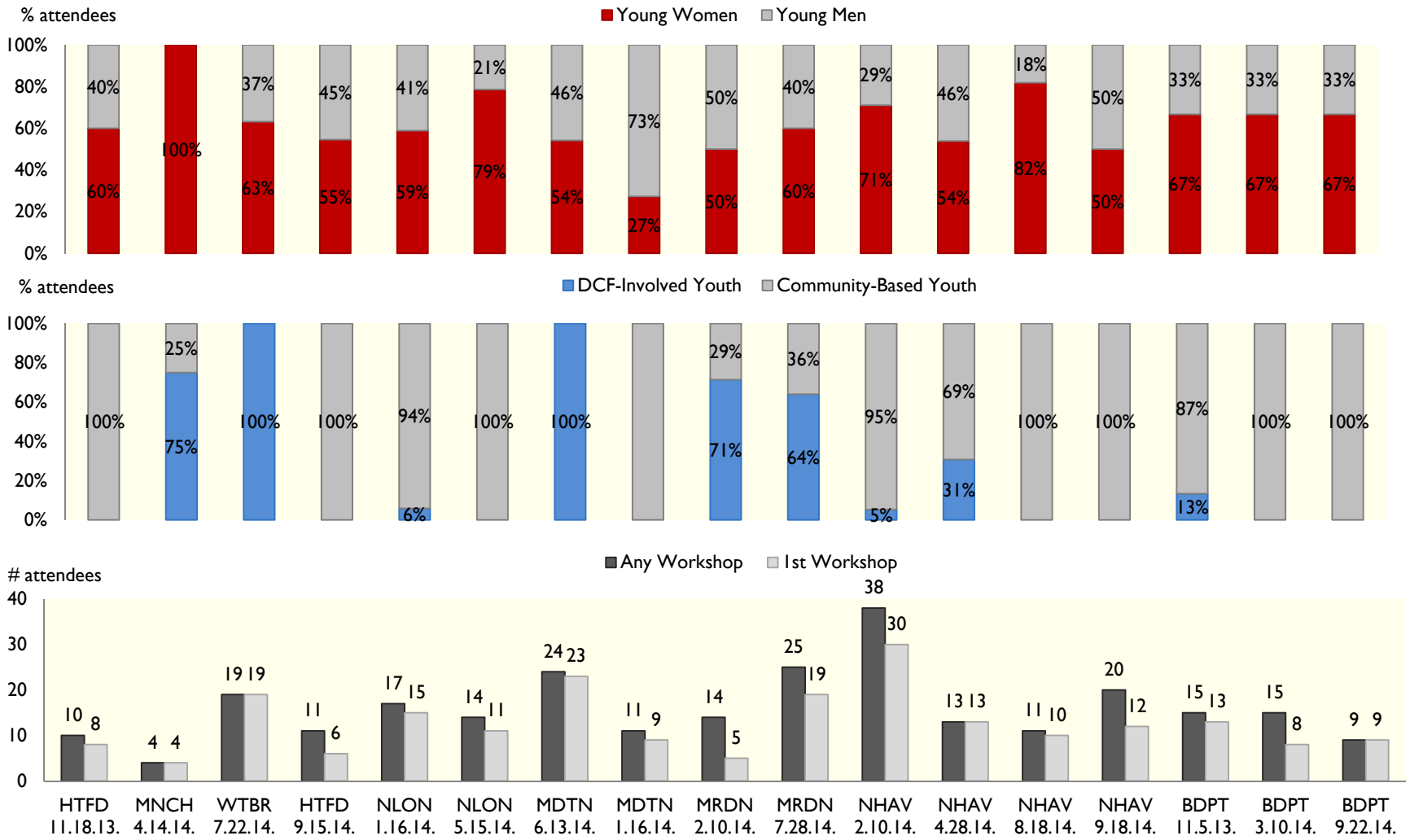
Patterns of attendance across *Teen Talk* series and for each series individually are presented in Figures 3a and 3b, respectively. What stands out is considerable variability across *Teen Talk* series in the number of participants, with a range from 4 to 38 youth. This is to say that some workshops were fairly small (as far as the number of participants goes), whereas others were relatively large. Another interesting piece of information is that 5 out of 17 series were conducted primarily for DCF youth but were also open to community-based youth. Conversely, 11 series were conducted for youth living in geographic areas with high rates of teenage pregnancy, although they also included DCF youth. Lastly, the proportion of participants who completed at least three workshops varied across the series. This variability is illustrated in Figure 4, which presents retention among those who attended the first workshop in each series.

Table 1. *Teen Talk Fidelity Monitoring: Rushed Sessions, Activity Shifting, and Activity Omission*

	Session Felt Rushed?				Activities Shifted or Omitted?						Comments
Teen Talk	**wksp1**	**wksp2**	**wksp3**	**wksp4**	**wksp1**	**wksp2**	**wksp3**	**wksp4**	**# wksp4 activities not done**	**total # activities not done**	
HTFD 11.18.13.		*		m	†	x	x	†	1	2	
MNCH 4.14.14.					†				0	1	
WTBR 7.22.14.	*	*	*	*	x	x	x, †	†	7	8	behavior mgt. difficulties in wksp 3; not able to do clinic tour or to do wksp 4 activities
HTFD 9.15.14.	*	*		m	x	x	x, †	m	m	m	ran an addt'l wksp for make-up and to complete wksp 4 activities
NLON 1.16.14.			*	*				†	2	2	
NLON 5.15.14.	*	*	*				†	†	1	2	youth left the last wksp early to attend an event at local high school
MDTN 6.13.14.	*	*	*	*		x, †		†	1	2	behavior mgt. difficulties; youth brought in late to wksps; end time fixed due to alarm
MDTN 1.16.14.	m	m	m	m	m	m	m	m	m	m	
MRDN 2.10.14.		*	*	*		x	†	†	1	2	youth brought in late due to traffic; new youth brought to last wksp – disruptive
MRDN 7.28.14.		*	*			x	x	†	1	1	
NHAV 2.10.14.	*	*	*	*			x	†	1	1	
NHAV 4.28.14.		*	*	*		x	x, †	†	1	3	
NHAV 8.18.14.				*	x, †	x	x, †	†	5	8	
NHAV 9.18.14.	*			*	†		x, †	†	1	5	ran an additional wksp for make-up and to complete wksp 4 activities
BDPT 11.5.13.	*	*				x			0	0	
BDPT 3.10.14.	*			*		x	x, †	x, †	1	2	youth were 15-20 min late coming to wksps; not able to do the clinic tour
BDPT 9.22.14.		*			†		†	†	2	6	not able to do the clinic tour

Note: * = session somewhat or very rushed; † = at least one activity not completed; x = at least one activity moved to the next workshop; m = missing data.
Fidelity checklist was not completed for the Middletown 1/16/14 series because this series was adapted for residents of a psychiatric hospital.

Figure 3a. Teen Talk *Attendance*[8]



[8] Middletown 1/16/2014 *Teen Talk* participants were young adults who, at the time of this *Teen Talk* series, resided in Central Valley Hospital (CVH) in Middletown, CT. One Man-to-Woman transgendered participant of the Meriden 7/28/14 *Teen Talk* was counted as a young woman for the purpose of this data presentation.

Figure 3b. Teen Talk *Attendance by Workshop Series*

For each workshop series presented are (1) the number of participants who completed any *TeenTalk* workshop, as recorded on the attendance log sheet, (2) the number of participants who attended the first workshop in a series, (3) the number of participants who completed at least 3 workshops, and (4) the number of participants who attended one workshop only. Additionally, among those who competed any *Teen Talk* workshop, presented are (5) the number of participants with DCF involvement and (6) the number of PPSNE STARs.

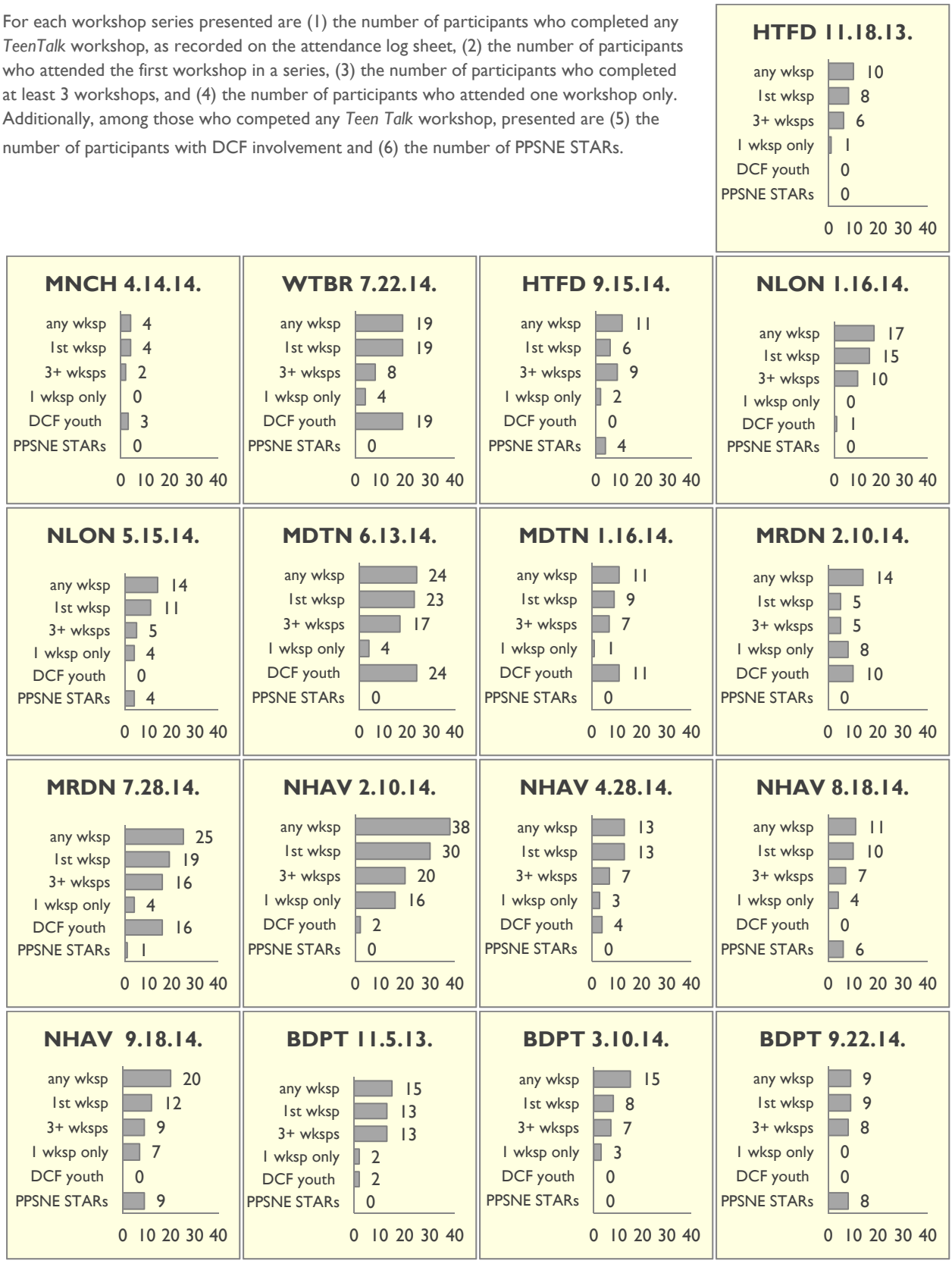


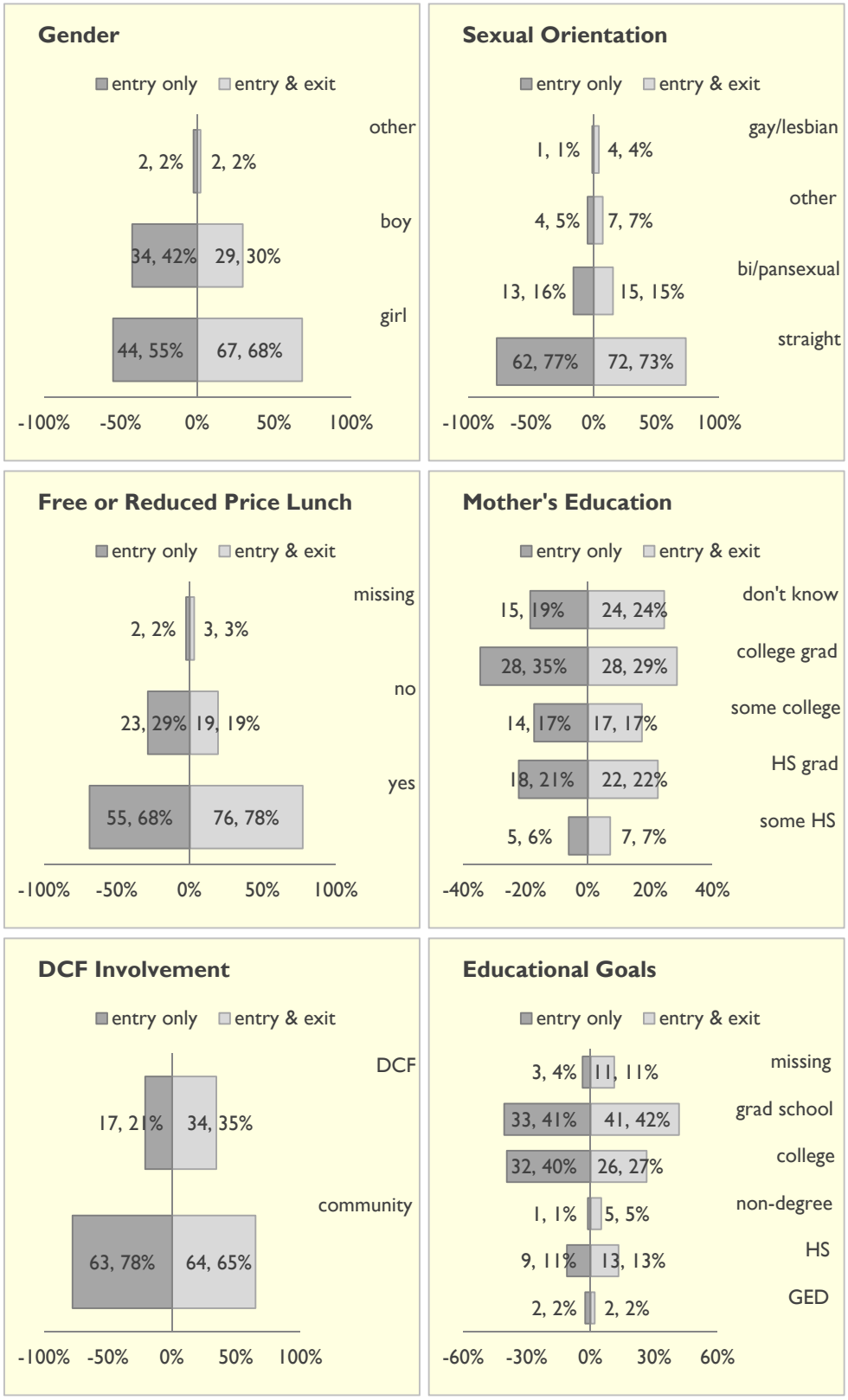
Figure 4. *Retention Among Participants Who Attended the First Workshop in a Series*

Teen Talk	1st wksp	2nd wksp	3rd wksp	4th wksp	Comments
HTFD 11.18.13.	8	75%	63%	63%	held over 3 weeks; 75% attended 3+ wksps
MNCH 4.14.14.	2	100%	100%	100%	missing attendance for 2 participants; held over 3 weeks
WTBR 7.22.14.	19	37%	32%	79%	all participants were DCF youth; held over 2 weeks; 42% attended 3+ wksps
HTFD 9.15.14.	6	100%	100%	100%	6 "old" STARs participated in some of the wksps; held over 4 weeks; 100% attended 3+ wksps
NLON 1.16.14.	15	100%	47%	40%	5 "old STARs participated in some of the wksps; held over 2 weeks; 53% attended 3+ wksps
NLON 5.15.14.	11	64%	45%	27%	2 "old" STARs participated in some of the wksps; high school event during 4th wksp; held over 3 weeks; 46% attended 3+ wksps
MDTN 6.13.14.	23	83%	61%	70%	all participants were DCF youth; held over 2 weeks; 70% attended 3+ wksps
MDTN 1.16.14.	9	78%	89%	78%	all participants were CVH young adults; held over 2 weeks; 78% attended 3+ wksps
MRDN 2.10.14.	5	80%	80%	100%	first workshop rescheduled twice due to a snow storm; held over 2 weeks; 100% attended 3+ wksps
MRDN 7.28.14.	19	74%	84%	63%	15/19 participants were DCF youth; held over 1 week; 79% attended 3+ wksps
NHAV 2.10.14.	30	63%	60%	47%	last wksp was cancelled and rescheduled due to a snow storm; held over 1 week; 63% attended 3+ wksps
NHAV 4.28.14.	13	77%	46%	54%	held over 1 week; 54% attended 3+ wksps
NHAV 8.18.14.	10	60%	70%	70%	6 new STARs participated in workshops; youth working summer jobs; held over 1 week; 70% attended 3+ wksps
NHAV 9.18.14.	12	92%	33%	42%	6 "old" STARs participated in wksps; 3rd workshop on a Jewish holiday; held over 2 weeks; 58% attended 3+ wksps
BDPT 11.5.13.	13	100%	100%	85%	held over 1 week; 100% attended 3+ wskps
BDPT 3.10.14.	8	75%	88%	63%	held over 1 week; 63% attended 3+ wksps
BDPT 9.22.14.	9	100%	78%	89%	8 new STARs; held over 1 week; 89% attended 3+ wksps

Program Participants

Figure 5. Teen Talk *Participants' Demographic Background Characteristics*

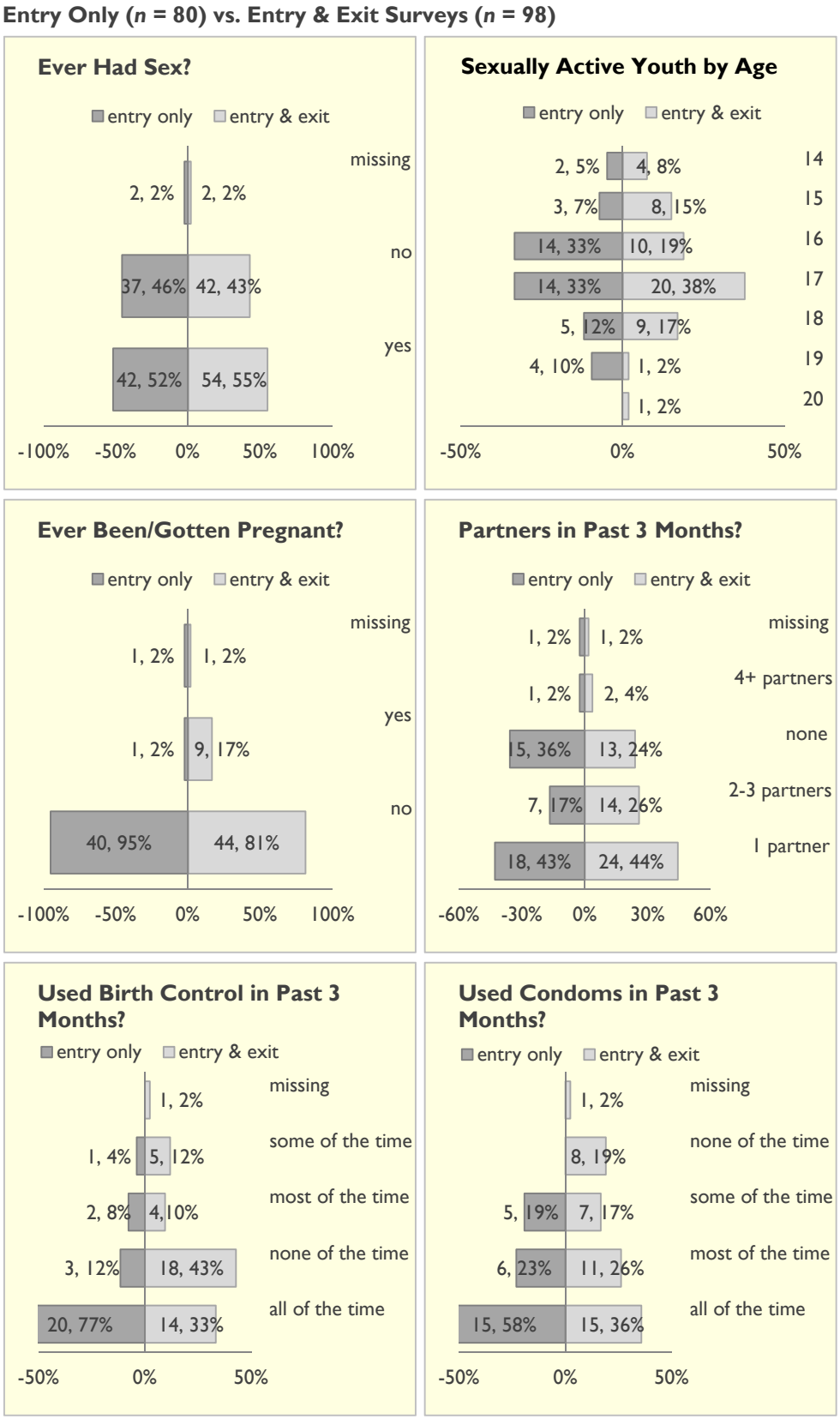
Entry Only (*n* = 80) vs. Entry & Exit Surveys (*n* = 98)



Comments

Participants who completed both surveys (*n* = 98) were similar to participants who filled out only the entry survey (*n* = 80) with respect to demographic background characteristics. Small differences between the two groups were observed with respect to gender (a greater proportion of girls completed both surveys), DCF involvement (a greater proportion of DCF youth than community-based youth completed both surveys), and the receipt of free/reduced-price lunch (a greater proportion of youth who received free/reduced-price lunch than youth who didn't completed both surveys). These observed differences were not statistically significant.

Figure 6. *Teen Talk Participants' Sexual Behavior*



Comments

Although there was no difference between those who completed both surveys and those who filled out only the entry survey with respect to sexual experience (i.e., the proportion of sexually experienced youth), those who completed both surveys reported more sexual risk-taking (prior to participation in *Teen Talk*). Namely, the "completers" were more likely to have been or have gotten someone else pregnant (p = .04, FET). They were also less likely to report that they used birth control "all of the time" in the past 3 months ($\chi^2(1, n = 67) = 11.6$, p = .001). It is worth noting that sexual risk taking among those who completed both surveys was not restricted to youth with DCF involvement: of 9 youth who reported that they had been or had gotten someone else pregnant, 4 had DCF involvement whereas 5 did not.

Program Perceptions

Figure 7. *Participants' Satisfaction with Teen Talk*

Comments

A large majority of participants expressed satisfaction with *Teen Talk*: 81 out of 98 (83%) reported that they had a chance to ask questions all or most of the time; 86 (88%) reported that discussions or activities helped them learn; 85 (87%) reported that material presented was clear; and 81 (83%) reported that they felt interested in program sessions all or most of the time. To put these numbers in perspective, consider the responses of participants who received PREP-funded sexual education (*Making Proud Choices!* and *Reducing the Risk* curricula) in schools during the 2013/14 school year: 343 out of 463 (74%) students reported that they had a chance to ask questions during a school-based PREP-funded sexual education program; 360 (77%) reported that discussions or activities helped them learn; 371 (80%) reported that the material presented was clear; and 255 (55%) reported that they were interested in the program all or most of the time.

Response Breakdown

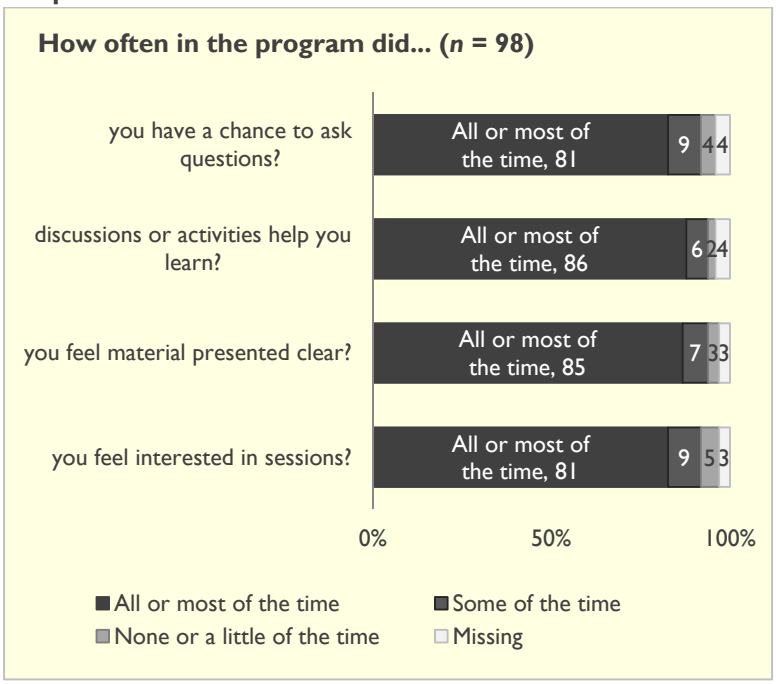


Figure 8. *Participants' Perceptions of Program Impact on Their Wellbeing*

Comments

A majority of participants (*n* = 66, 67%) reported that being in *Teen Talk* made them more likely to talk about things that really matter with a parent or guardian. Additionally, although *Teen Talk* is not designed to address friendships and educational intentions, a majority of participants reported on exit surveys that *Teen Talk* influenced them on these matters: 64 (65%) reported that being in *Teen Talk* made them more likely to care about doing well in school; 59 (60%) reported that they were more likely to form friendships that kept them out of trouble; and, 73 out of 98 (74%) reported that they were more likely to resist or say 'no' to peer pressure as a result of being in *Teen Talk*. These numbers are similar to, and in some instances greater than, the numbers from PREP-funded programs in schools: 234 out of 463 (51%) students reported that being in a PREP program made them more likely to talk about things that really mater with a parent or guardian; 298 (64%) reported that being in the program made them more likely to care about doing well in school; 273 (59%) reported that they were more likely to form prosocial friendships; and, 320 (69%) reported that they were more likely to resist peer pressure.

Response Breakdown

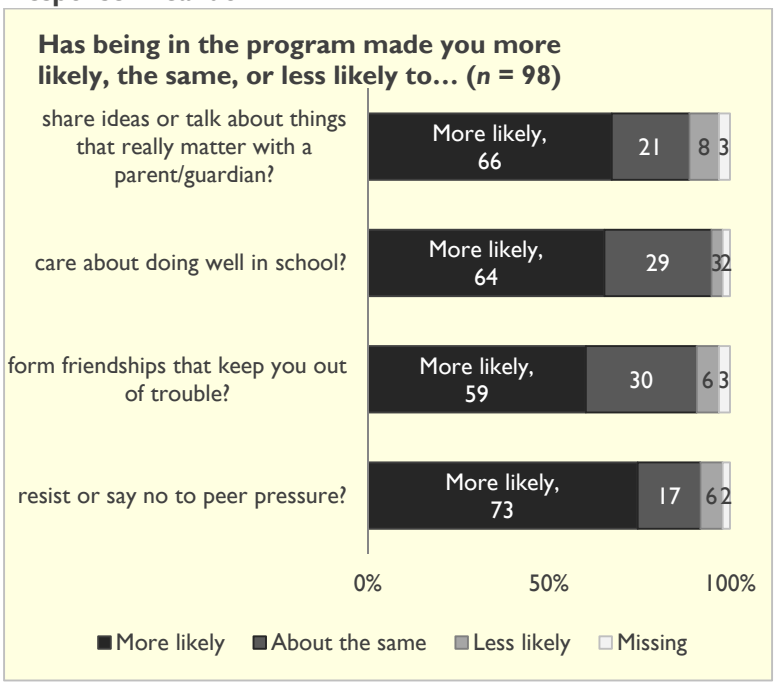
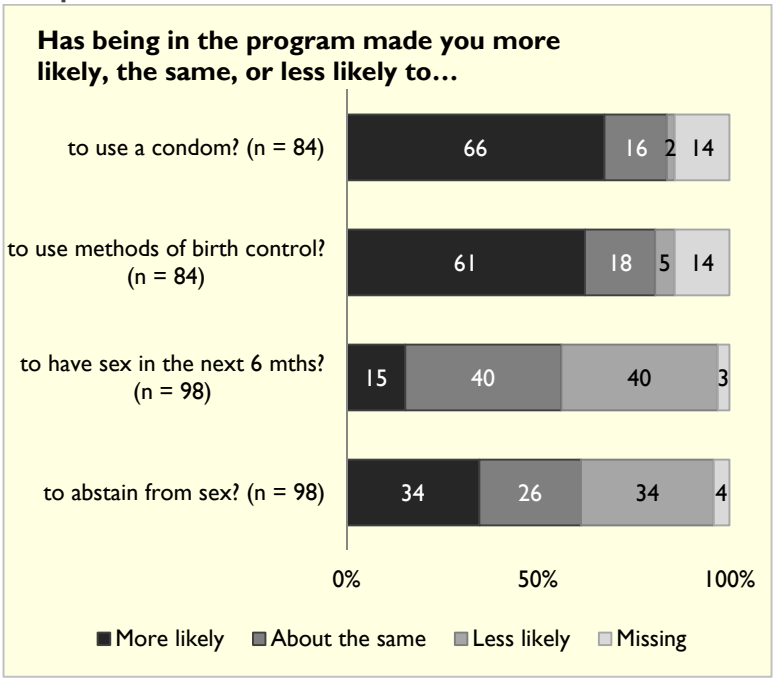


Figure 9. *Participants' Perceptions of Program Impact on Their Sexual Behaviors*

Response Breakdown



Comments

A majority of *Teen Talk* participants reported on exit surveys that being in the program made them more likely to contracept: 66 out of 84[9] (78%) reported that they were more likely to use a condom as a result of being in *Teen Talk* and 61 out of 84 (73%) reported that they were more likely to use methods of birth control (broadly defined). In terms of the perceived impact on participants' intention to have sex, 40 out of 98 youth (41%) reported that they were less likely to have sex and a relatively small proportion of participants (*n* =15, 15%) reported that they were more likely to have sex as a result of being in *Teen Talk.* Regarding perceived impact on abstinance, equal proportions of participants (*n* = 34, 35%) reported that being in *Teen Talk* made them either more or less likely to abstain from sex. These numbers are similar to the numbers from PREP-funded programs in schools: 257 out of 330 (78%) students reported that they were more likely to use a condom; 244 out of 330 (74%) that they more likely to use birth control; 205 out of 463 (44%) that they were less likely to have sex; and 214 out of 463 (45%) that they were more likely to abstain.

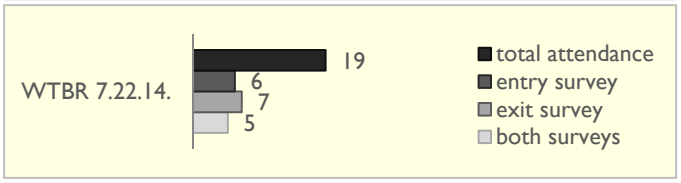
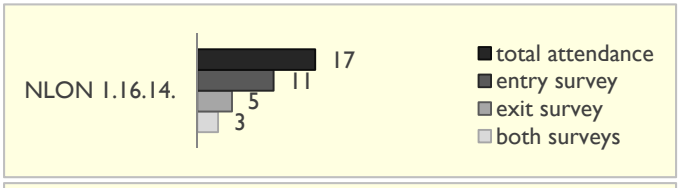
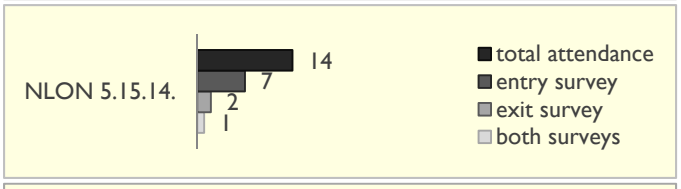
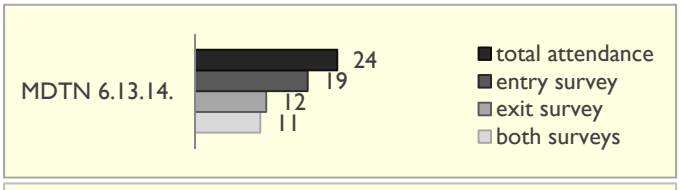
Exit surveys suggest high levels of satisfaction with *Teen Talk* and a perception of *Teen Talk* as having a positive impact on participants' general wellbeing and sexual risk taking. What is more, participants' ratings of *Teen Talk* are comparable to student ratings of PREP-funded evidence-based programs (*Making Proud Choices!* and *Reducing the Risk*) implemented in Connecticut's schools. In interpreting this comparison, it is important to consider contextual differences and differences between the populations served by these programs:

1) The rate of exit survey completion was considerably higher among school-based youth than among *Teen Talk* participants (90% vs. 55%, respectively). Additionally, students are a "captive audience" whereas *Teen Talk* participants attend workshops on their own initiative. Hence, that *Teen Talk* participants reported higher levels of satisfaction than school-based participants[10] may or may not reflect a higher level of satisfaction with *Teen Talk* than with other sex education programs funded by State PREP.
2) A higher proportion of school-based participants than *Teen Talk* participants reported that they were more likely to abstain from sexual (vaginal) intercourse in the six-month period following exit survey completion as a result of their PREP-funded sex education program. The interpretation of this observed difference must be tempered by the following considerations: *Teen Talk* participants were older, on average, than school-based participants (16.0, SD = 1.4 vs. 14.7, SD = 1.1). Also, a much greater proportion of *Teen Talk* participants than school-based youth reported that they had sexual intercourse in the past (55% vs. 22%).

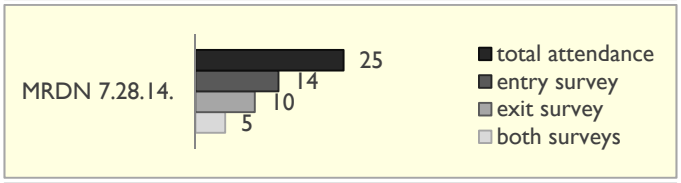
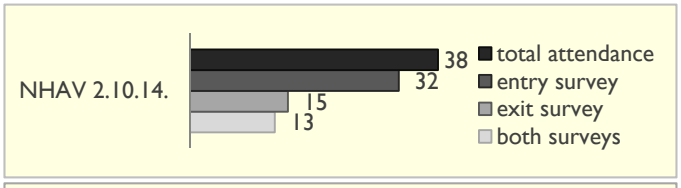
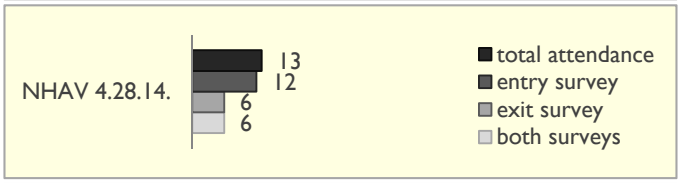
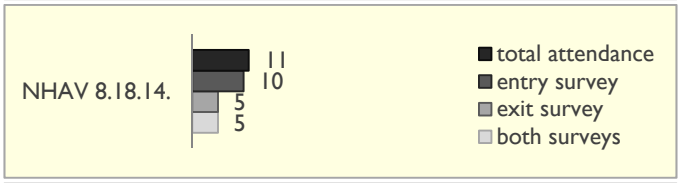
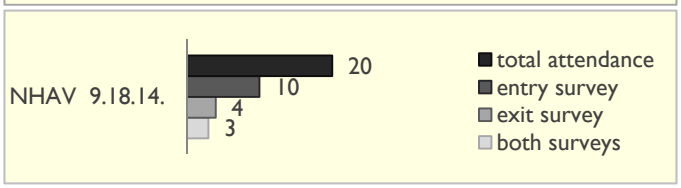
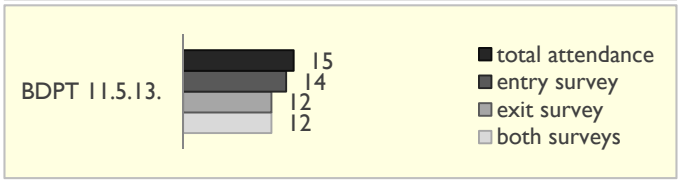
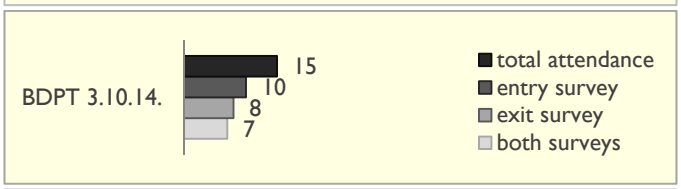
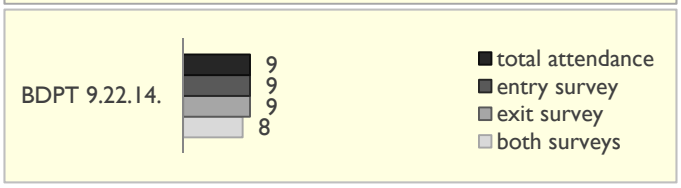
[9] Only the responses of those participants who entertained the possibility of having sexual intercourse in the 6-month period following exit survey completion were included in the count—hence 84 instead of 98 responses.
[10] For example, 83% of *Teen Talk* participants in contrast to 55% of students in schools reported on exit surveys that they felt interested in program sessions.

Evaluation of the Evaluation

Figure 10. *Program Attendance vs. Questionnaire Completion*[11]

Comments	Teen Talk
3 participants did not attend the last wksp. One attended only one wksp.	
Attendance records not available for 2 participants. They most likely attended at least the first and the last workshop, if not all of them.	
11 participants reported that they participated in the past and so did not complete surveys. 4 attended the first wksp only and did not complete exit surveys.	
2 participants attended only the 3rd or 4th workshop and so did not complete surveys. It is unclear why others surveys are missing.	
15 attended the 1st wksp—not clear why 4 entry surveys were not completed. 9 participants did not attend the 4th workshop and, therefore, did not complete exit surveys.	
One "old" STAR attended only the 3rd workshop. 3 others attended one workshop only. 3 others were "old" STARs who participated in Teen Talk in the past. 11 attended the first wksp.	
One participated in the past. 2 refused. 4 attended the first wksp only and did not complete exit surveys. One of them did not complete entry survey.	
Young adults, all CVH residents. Did not participate in the evaluation.	

[11] Nine entry survey cases were removed in the process of data cleaning: 6 repeat attendees, 2 blank surveys, and 2 surveys that bore unequivocal signs of "monkeying." Four exit cases were removed: 3 repeat attendees and 1 survey with responses indicative of "monkeying."

Teen Talk	Comments
	6 participants attended only the 3rd or the 4th wksp. 2 attended the 2nd wksp only. Altogether, 8 participants attended only one, and one attended only 2 wksps.
	One participant attended only the 3rd or the 4th wksp. 3 attended the 2nd wksp only and did not complete the surveys. 4 were previous attendees. 2 refused. One put down whatever.
	7 participants attended only the 3rd or the 4th wksp. Another 9 attended only one wksp and did not complete an exit survey. 2 were repeat attendees and were excluded from the entry/exit count.
	3 attended the first wksp only and did not complete exit surveys. 2 attended the first two wksps only. 2 participants were repeat attendees.
	One was a repeat attendee and was removed from the entry survey count. 4 attended only one wksp and didn't complete exit surveys. Not clear why 1 exit is missing.
	9 "old" STARs had participated in *Teen Talk* in the past. One did not complete the entry but completed the exit survey. Only 3 attended the last wksp and completed exit surveys.
	2 participants attended only the 3rd or the 4th workshop; one of them completed the entry but not the exit, and the other completed neither.
	3 participants attended only the 3rd or the 4th workshop and, hence, did not complete the surveys. 5 were repeat attendees.
	Attendance is, possibly, missing for one participant. One participant completed an entry survey but not an exit survey.

Outcome Evaluation

In addition to questions about participants' perceptions of program impact, exit surveys included measures of 1) knowledge about contraception; 2) attitude toward using protection in a long-term relationship; and 3) self-efficacy to say 'no' to sex and to insist on using contraception. Additionally, both entry and exit surveys included a question about participants' intentions to have sexual (vaginal) intercourse in the six-month period following survey completion.

Knowledge scores for each workshop series are presented in the top part of Figure 11. The results suggest a high degree of variability across workshop series, with an average of 87% correct answers on the high end and an average of 50% correct answers on the low end.

Attitude and self-efficacy scores are presented in the middle part of Figure 11. Attitude items were rated on a scale from 1 to 6, with 1 indicating disagreement and 6 indicating agreement with the idea that protection is NOT needed with long-standing partners. Across workshop series, average scores were relatively low (from 1.0 to 2.4), thus indicating high levels of disagreement. That said, workshop series conducted specifically for DCF youth had higher attitude scores on average than the series conducted for community-based youth (b = .49, p = .03), thus suggesting greater levels of agreement (among participants in workshop series for DCF youth) with the idea that protection is NOT necessary in long-term relationships.[12]

Self-efficacy items were rated on a scale from 1 to 4, with 1 indicating lower levels of self-efficacy and 4 indicating higher levels of self-efficacy. As with knowledge and attitude scores, there was a high degree of variability across workshop series, ranging from an average score of 1.9 on the low end to an average score of 4.0 on the high end. What is more, the series that were conducted specifically for DCF youth had lower average scores than the community-based series on a measure of self-efficacy to insist on using protection (b = -.49, p = .025) and a measure of self-efficacy to refuse sex with a romantic partner (b = -.51, p = .05).

Lastly, intentions to have sexual (vaginal) intercourse on entry were compared to intentions on exit from *Teen Talk* (Figure 12). A large majority of participants (64/98) did not change intentions to have sex in either direction. Among sexually experienced youth, 11 out of 54 (20%) experienced a decrease in intentionality. Of those, 6 went from "yes, definitely" or "yes, probably" at the entry survey to "no, probably" or "no, definitely" at the exit survey. In contrast, 7 out of 54 sexually experienced youth (13%) experienced an increase in intention to have sex, but none of them shifted from "no" at entry to "yes" at exit—in other words, changes in intention were within the "yes" and "no" categories.

Among sexually inexperienced youth, 1 out of 42 experienced a decrease in the intention to have sexual intercourse in the 6-month period following the program. Ten (23%) experienced an increase in the intention to have sex: 3 shifted from "no" at entry to "yes" at exit, whereas 7 experienced smaller changes (i.e., from "no, definitely" at entry to "no, probably" at exit or from "yes, probably" at entry to "yes, definitely" at exit).

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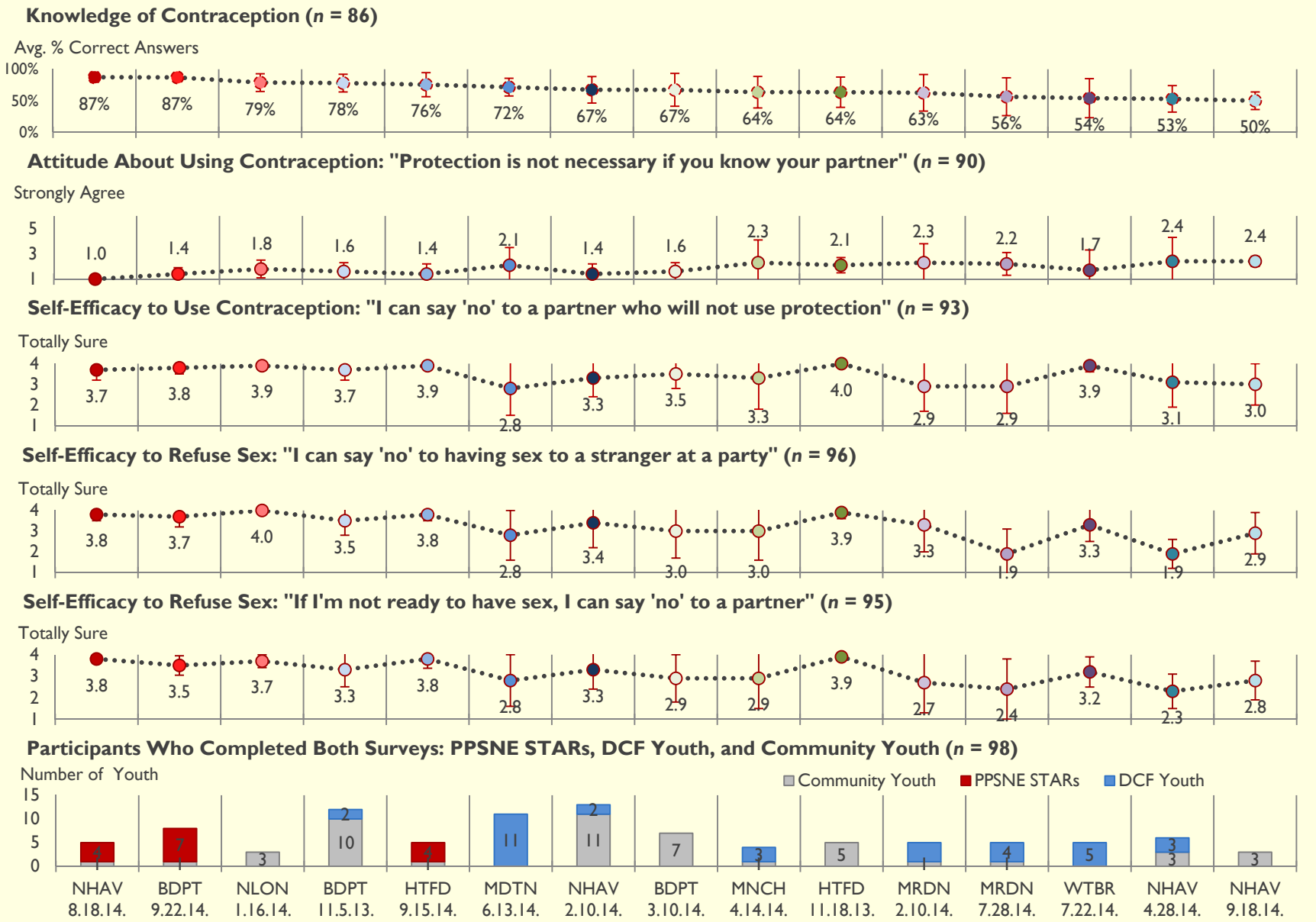
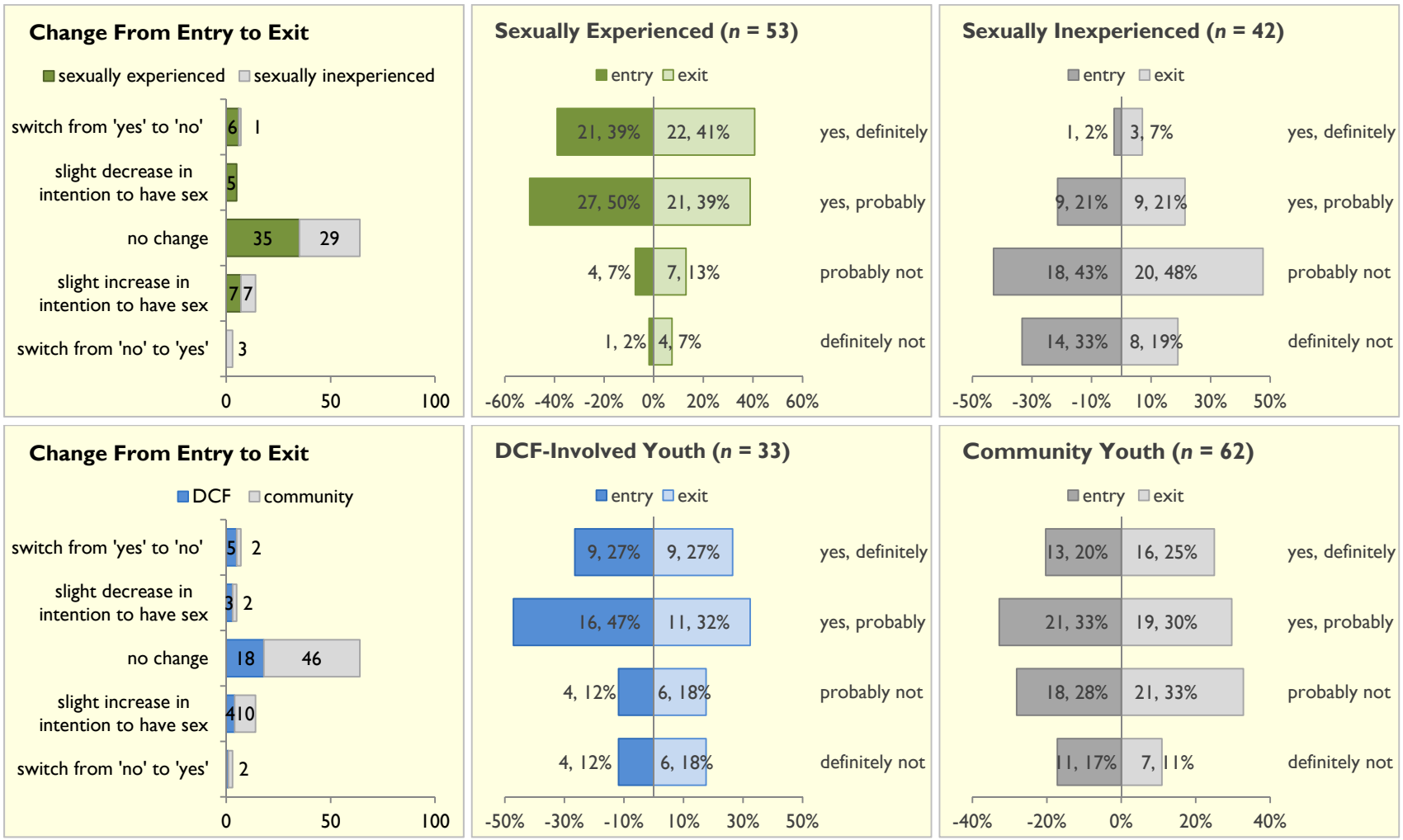
[12] Weighted least squares, with the number of respondents in each series as a weight, was used to estimate the difference between *Teen Talk* series conducted specifically for DCF youth and *Teen Talk* series held in community settings.

Figure 11. *Exit Survey Knowledge, Attitude, and Self-Efficacy Scores Across* Teen Talk *Series*[13]



[13]New London 5/15/2014 is not displayed because scores were available for only one person who attended this workshop series.

Figure 12. *Intentions to Have Sexual (Vaginal) Intercourse in the Following Six-Month Period: Entry v. Exit*



Conclusions

In 2013/14, PPSNE held 17 *Teen Talk* workshop series: 11 in communities with high rates of teenage pregnancy and birth, 5 with residents of congregate care programs operated by Connecticut's child welfare system, and one with inpatients in a psychiatric hospital. Workshop series were generally implemented as intended: each series included four 2.5-hour long workshops and the workshops covered activities specified in the *Teen Talk* curriculum. That being said, facilitators and workshop observers reported that over half of workshops had a "rushed feel"; additionally, activities were shifted from one workshop to the next or omitted altogether in most workshop series. In response to *Teen Talk* facilitators' feedback about time shortages, PPSNE worked in the second half of 2013/14 on condensing the curriculum. The revised curriculum is currently being pilot-tested in Rhode Island.

Across the 17 workshop series, there were 270 attendees, 262 of whom were unique. Participants ranged in age from 13 to 23, with an average of 16.4 years old. A large majority of participants (84%) were youth of color, and about 60% of them were young women. The retention rate among participants who attended the first workshop in a given *Teen Talk* series was 68%. Considering the fact that *Teen Talk* is a community-based program and that participants are not incentivized to attend workshops, this rate is fairly good. It does, however, fall short of the FYSB goal of having at least 80% of participants attend at least 75% of the program.

Teen Talk participants reported high levels of satisfaction with the program. In particular, a large majority of participants reported that they had a chance to ask questions, they felt interested in program sessions, discussions or activities helped them learn, and material presented was clear. Additionally, participants reported that *Teen Talk* positively influenced their educational intentions and their ability to form prosocial friendships and resist peer pressure. Furthermore, they reported that *Teen Talk* positively influenced their intentions vis-à-vis sexual behavior: a large majority indicated on exit surveys that they were more likely to use condoms and birth control as a result of being in *Teen Talk*. These findings are consistent with exit survey reports of participants who received PREP-funded sex education programming in Connecticut's schools.

Regarding changes over time in participants' intentions to have sex, a large majority of participants did not experience a change in either direction. That being said, it is important to emphasize that a small but significant number of sexually-experienced participants (6/54) switched from intending to have sex on entry to not intending to have sex on exit from *Teen Talk*; in contrast, none of the sexually experienced participants switched from not intending to have sex on entry to intending to have sex on exit from *Teen Talk.*

Lastly, the findings presented in this interim report point to areas of growth and recommendations for future implementations of *Teen Talk.*

Recommendations

Attendance

- Record on the attendance log an ID code for <u>each</u> participant (regardless of whether they completed the entry survey).

- Use the same protocol for assigning ID codes for all workshop series.
- Include three additional fields on the attendance log: (1) PPSNE STAR status (old STAR vs. new STAR vs. not a STAR), (2) DCF status, and (3) repeat attendance status.
- Ensure that all educators share a common understanding of guidelines for attendance keeping (ex. do not log STARS who are co-facilitators, but log other STARs; include on the log those participants who attended only one workshop, even if that's the last workshop in a series).

Fidelity Monitoring

- Ensure that each educator is observed by a colleague (either in person or via an audio-recording) in the course of at least one workshop series.
- Observe the 2nd or the 3rd implementation of *Teen Talk* for each educator.

Survey Administration

- Administer entry surveys prior to the first workshop, and for those who join T*een Talk* on day 2 in a series, prior to the second workshop.
- Administer exit surveys after the completion of the last workshop in a series.
- Administer surveys to attendees regardless of STAR, DCF, and prior attendance status.
- Develop a script for educators to administer the surveys.

Teen Talk Implementation

- Consider providing a condensed version of the *Teen Talk* curriculum during the PREP FY 2014/15.
- Consider adding a co-facilitator to *Teen Talk* workshops offered to DCF youth.
- Consider setting an upper limit for the number of participants in workshops conducted for youth with DCF-involvement.
- Consider advertising a 30-min earlier start for the workshops conducted for youth with DCF-involvement.
- Consider holding "closed" rather than "open" groups for youth with DCF involvement. Including new attendees—whether community-based youth or DCF youth—in the 3rd or 4th workshop might disrupt the group process and create behavior management difficulties.
- Insist during workshop scheduling that DCF or group home staff be available to assist youth who may be experiencing emotional difficulties/re-traumatization during *Teen Talk*.
- Consider including in *Teen Talk* only those youth who are deemed mature by their social workers and who elect on their own to participate in *Teen Talk.*

General

- Discard all existing fidelity forms, attendance forms, and PREP questionnaires. Distribute new forms and photocopies for the whole fiscal year.

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Appendix A – Teen Talk Logic Model

Intervention Activities	Determinants (Risk and Protective Factors)	Behaviors	Health Goal
Knowledge: Brainstorming, large group discussions, activities getting to myths and facts about STD's, HIV, pregnancy, contraception, and health in relationships, Risk Continuum activities, condom line up, birth control demonstrations, anatomy activities that include menstruation, pregnancy, and wet dreams, presentation of local stats, tour of health center, meeting health center staff. **Personal Values:** What is it like to talk about sex; values voting (forced choice) activities about pregnancy choices; activity about who takes responsibility for safer sex, contraception, and safety; reading of stories to talk about responsibility, respect, and pressure; talking to your partner and negation skills activities. **Attitudes about:** Brainstorming; large group discussion; values voting (forced choice) activities; talking to your partner about condoms, safer sex, abstinence, and relationships; talking about barriers to getting BCM; going on a health center tour and meeting health center staff. **Perception of risk/vulnerability to:** Body part pairing activity, HIV risk continuum discussion, birth control methods discussion, pregnancy options/choices activity, relationship stories about power and control, discussion about how to help friends in unsafe situations. **Skills and Self-Efficacy related to:** Writing safer sex dialogues and role playing safer sex talks, practicing putting on a condom and the condom line up activity, talking about barriers to condom use, responding to pressure comments from partners, negotiation skills, tour of health center, meeting health center staff.	**Knowledge:** 1. Increase knowledge about reproductive anatomy, puberty, pregnancy, contraception, and STD/HIV. 2. Increase knowledge about how to access reproductive health services. **Personal Values about:** 1. Increase personal belief that contraception is important and STD/HIV prevention is important. 2. Increase belief that condoms do not necessarily reduce sexual pleasure. **Attitudes about:** 1. Increase positive attitudes towards condoms and other forms of contraception. 2. Increase positive attitudes about healthy relationships. 3. Increase positive attitudes about accessing reproductive health services. **Perception of risk/vulnerability and Perception of peer norms:** 1. Increase motivation and intent to avoid pregnancy, HIV, and other STDs. 2. Increase motivation and intent to avoid unhealthy relationships. **Skills and Self-Efficacy related to:** 1. Increase intent to have conversations about pregnancy and STD prevention with partner. 2. Increase intent to access reproductive health services. 3. Increase intent to use condoms.	1. To increase the use of condoms 2. To increase the use of contraception 3. To reduce number of sexual partners 4. To reduce frequency of sex.	To decrease rates of teen pregnancy and STD/HIV among area teens aged 14-17.