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The Communicative-Relational Operating Model of the Italian National Institute of Health for an Effective Telephone Intervention in Public Health, Structured on Basic Counselling Skills

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Key words: Telephone Communication, Helpline, Operative Model, Counselling basic skills, Sexually Transmitted Infections, Addictions, Rare Diseases
Parole chiave: Comunicazione, Intervento Telefonico, Modello Operativo, Competenze di base del Counselling, Infezioni Sessualmente Trasmesse, Dipendenze, Malattie Rare

Abstract

Introduction. *Communication has a crucial role in public health, because it becomes an essential component of prevention; it is also a proactive tool in health promotion. From a planning perspective, it is appropriate to use communication means that can help the bidirectional communication process, such as face-to-face communication and telephone communication.*
Materials and methods. *In relation to this, the Italian National Institute of Health has developed the "Modello Operativo Comunicativo-Relazionale" (the "Communicative-Relational Operating Model"). It is based on the fundamental skills of the counselling, this gives a protocol to the health professionals that is replicable and organized and it allows health professionals to carry out a telephone communication that is efficient with the user through technical-scientific and communication-relational skills. The goal is to answer in a customized way to the various users' health needs.*
The Operating Model was created by experts of the National AIDS and Sexually Transmitted Infections Helpline of the Operational Unit of Psycho-Socio-Behavioural Research, Communication, Training, of the Infectious Diseases Department. Later, the Operating Model was proposed to the experts of the Helplines

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in the National Centre on Addictions and Doping and the National Helpline of the National Centre for Rare Diseases in the National Institute of Health that integrated this method into their telephone approach.
Results. *The Operating Model illustrated above was applied to several helplines of the National Institute of Health as an example of correct scientific information, updated and customized on sexual transmitted infections, addictions and rare diseases.*
Conclusions. *This article aims to illustrate the Operating Model, the theoretical prerequisites that subtend it and its possible application in the different public health structures that use the telephone for a professional relationship with their users.*

Introduction

Communication has a crucial role in Public Health, because it becomes an essential component of prevention; it is also a proactive way to promote health. Communication contributes to expand knowledge through a flow of correct and comprehensive information that can induce awareness and empowerment on both individual and community levels of citizens (1). Communication can:

- support the exchange and the interaction between every subject in the building of health awareness;
- enhance the role of different Health professionals in public health services that help the prevention of pathological states and in health promotion;
- simplify the creation of institutional webs and collaborations between health organizations, and this can make the interventions more efficient.

Health communication means using communication in a competent way and focusing on offering a contribution to the entire disease prevention and health promotion.

In this perspective, every communicational action gains meaning and intensifies its effectiveness since it is seen and conducted in a strategic planning made with various communications means linked with each other. The goal is to facilitate the traffic of up-to-date, clear and comprehensive information, uniform messages that can answer every need or doubt or target, and can be used to make healthy choices in order to maintain or improve their quality of life (2).

Today we have many sources but all of that abundance of information can lead to confusion. Technology, the internet and the "social" network have caused a drastic change. Now, information is searched and shared initially on the internet and only subsequently verified by the right people.

Health professionals in public health services have the opportunity to interact directly with people using people-to-people contact. These actions aim to reach educational and behavioural goals, they complete training interventions focused on the improvement of knowledge. They are created with unidirectional communication means, such as awareness campaigns with websites, spots, letters, and posters.

Hence, in a planning perspective of the communication initiatives, if the communication goals do not aim just to improve knowledge but also to modify knowledge, attitudes and behaviours, it is necessary to use communication means that can help the bidirectional communication process such as communication face to face or telephone communication. The two-way communication process within an effective professional relationship can contribute to increasing the level of health literacy of the citizen, as it facilitates not only the passing on of correct information, but also enables its understanding to be verified, so that the

person can actively and consciously use it to make health-promoting choices (3).

This approach is also aimed at developing in the person the motivation and skills necessary to activate processes of change and empowerment (4).

Such a structured communication constitutes an added value to the professional relationship between operators and citizens, as it creates the conditions to grasp the convictions, perceptions and values of the user and thus to implement a customized intervention, centered on the expectations and needs of that specific person at that particular moment. All this can represent an important opportunity to develop the level of health literacy and to strengthen the individual and social dimensions of empowerment, such as self-esteem, self-efficacy, locus of control, participation and, consequently, to promote health and wellbeing for all with a view to equity (5).

The methodological approach that characterizes the telephone communication of the toll-free telephones of the National Institute of Health (Istituto Superiore di Sanità - ISS), which for many years has constituted a bridge between the citizen and the health system, is placed in this perspective.

The ISS, major research centre, control, consultation in public health and technical scientific order of the National Health Service, was the first public authority to use the telephone as a piece of scientific information addressed to the population and specific targets. Actually, in 1987, the ISS has activated in collaboration with the Ministry of Health, the "National AIDS and STI Helpline (Telefono Verde AIDS e Infezioni Sessualmente Trasmesse - TV AIDS & IST), this service is located in the communication area of the "Unità Operativa Ricerca psico-socio-sanitaria, Comunicazione, Formazione (UO RCF) of the Department of Infectious diseases (Dipartimento Malattie Infettive - DMI)".

In particular, the researcher of the UO RCF, through the daily commitment to the TV AIDS and IST, have created a Communicative-Relational Operating Model (Modello Operativo - MO), based on the basic skills of counselling, finalized to give to every health professionals in the public health service, regardless of the professional role, a reference protocol, replicable and organized (6).

This model can give to the health professionals in the public health services the opportunity to develop an effective telephone communication with the user aimed to answer in a customized way through the assimilation of technical-scientific and relational-communication skills (7).

The methodological planning of the MO was elaborated focusing on the principles and the recommendations of the WHO (Global Programme on AIDS. Psychosocial counselling for the person with HIV infection, AIDS and related disease. Geneva, 1989) regarding the counselling intervention, keeping in mind the difference between the basic counselling skills and the professional counselling seen as a proper and specific professional activity (8).

The MO was proposed, through a recurring meeting, to other experts in the various helplines of the ISS: Quitline Smoking (Telefono Verde contro il Fumo - TVF) and the Alcohol Helpline (Telefono Verde Alcol - TVA), active since 2000, the Anti-Doping Helpline (Telefono Verde Anti-Doping - TVAD), active since 2008, the Drug Addiction Helpline (Telefono Verde Anti-Doping - TVAD) active since 2009 and the Gambling Helpline (Telefono Verde Nazionale per le Problematiche legate al Gioco d'Azzardo - TVNGA), active since 2017, all staying at the National Centre on Addiction and Doping, and National Helpline for Rare Diseases (Telefono Verde Malattie Rare - TVMR), active since 2008, that have added this model into their telephone approach.

All of the ISS telephone services use researchers in the prevention and communication area, every service for their own health subject matter. Moreover, they use a strict method of telephone communication in public health, organized and based on counselling basic skills.

The MO prepared by the UO RCF is proposed as a communicative-relational reference protocol for the first level telephones in the SARS-CoV-2 pandemic (9).

In light of this, this article wants to illustrate the MO, the theoretical requirements and their users.

Materials and methods

The MO method of telephone communication in public health can represent a professional relationship between the competent professional and the user in need. The advantage of this method is the opportunity to give scientific customized information through a focused conversation. This information cannot be misunderstood and both advance independent decisions so that they can face problematic situations.

The MO method, depending on the context and the target, can satisfy many aims:

- give information supported by solid scientific bases in a customized way that can respond to a specific health need;
- help users to find out tools that can be useful to see the "real problem" and stimulate the search for possible solutions;
- help users in times of crisis offering the support they need to face the situation;
- help users to make a useful decision, so modifying behaviour that can put in danger their health;
- lower the risk of possible state of anxiety and discomfort.

From this perspective, telephone communication is a support for the user. It is not an approach aimed to persuade, give advice or force. The approach used by the researchers in the helplines of the ISS, is divided into three phases:

- first phase: it is fundamental to establish an empathy and trust relationship with the user and, in this phase, it is important to understand and focus on careful listening to the users' needs. It is important to focus on the request (verbal communication) and on the emotional aspects (para-verbal communication);
- second phase: it is characterized by the need to give the users the acknowledgement they need to find their "real" problem. It is important to find a goal to work on and to give information and customized indications in an understandable way. This phase is crucial to talk about possible solutions and to stimulate the user to choose in an autonomous and informed way the best solution;
- third and last phase: it is necessary to summarize the conversation and to verify that the information is understood. It is likewise important to sensitize the user about his health and to close the communication (10, 11).

These phases are found in the MO. This model was realized, tested and evaluated in different public health sectors in the research projects promoted and supported the Ministry of Health, conducted with the UO RCF in the ISS. The MO can build a map for the operators that they can use in different health sectors and it has the function to give, to the expert, a standard path that can answer every question in a suitable way. This path should not be seen as a strict path that cannot be changed, but as a conceptual flexible map that has to be adapted to every user, his story and his socio-cultural context, as well as his health history. The MO's aim is to give the operator a dynamic tool that is essential to have a productive telephone relationship with the user.

MO's structure

In the first phase of the telephone conversation, the operator has to focus on the internal and external settings. The internal setting is the space that the professional makes available to the user; the operator has to be self-conscious. The external setting is the physical context where the relationship is in place; this setting is not shared, and this is why the internal setting of the operator is more relevant. In this first part, welcoming the user is fundamental because it can create a positive mood. The first words and the para-verbal aspects (tone of voice, volume, rhythm, pauses and silence) can give much information to the operator. At the same time, the user listening to the opening words of the telephone conversation can perceive a welcoming mood or a cold mood.

Active listening to what the users say, can:

- focus on the problem that the users have and clarify what they know and what they want to know;

- summarize and give back, through rephrase and clarification techniques, what was heard without reading into the words.

A laid-back mood, a positive and welcoming behaviour, a clear and comprehensive language can help to focus on topics that the users think are relevant.

In the second phase of the telephone conversation, the actions have to focus the attention on making the users self-conscious of their "real" problem to identify the shared goal. To achieve this goal, the operator has to give customized information that has meaning to the user because it is focused on his individual needs and it has to be given considering what the user can actually listen to. The information has to be scientific, correct, complete and updated, given in an easy language for the specific user. It is important to answer a question at a time, verifying the reaction of the user, considering that every piece of information will emotionally touch the user. The operator's attention should always imply what to say and how the information will be perceived considering the users' emotions. Furthermore, in the second part a fundamental section is the identification of a shared goal and the right solutions to achieve it. The users have to be included in the decision, so that they can act to face their need and they can support a potential proposal to ask for further help in their territory. The users should have a propositional role in their health organization and - to face the crisis and find themselves - they should be active in the change.

In the last phase of the telephone conversation, the acts of the MO are aimed to summarize what was said, agreed upon and to verify that the user has understood the information. Before hanging up, it is useful to offer availability for further contact if the operator can book an appointment in the structure. Eventually, the conclusion of the telephone call has to be an empathic greeting (Scheme 1).

The relationship conducted following the MO guidelines cannot be confused with friendship because in a friendship the borders of identification and involvement are very blurred, the relationship has to be authentic but it has to have a communication strategy that helps in the shared goal that the user and the operator find out together.

To apply the MO within telephone communication, the operator has to be skilled in general, and has to have the basic skills of counselling:

- knowledge of the telephone communication's goal, that is not to give general information but it is based on simplifying the activation of the users' resources that can help them face in a responsible way problems and difficulties;

- knowledge of the processual scheme that is necessary to structure the telephone communication in the MO;

- availability and being able to work in a team and on the web;

Scheme 1 - Actions of the MO

The first part of the MO –The initial phase of the call

- Prepare the internal (self-awareness) and the external setting (dedicate time in a non-shared place)
- Welcome the user (greeting and introduction)
- Active listening (Using empathic techniques: reformulation, first person speaking)
- Focus on the real problem
- Find out what the user wants to know
- Clarify what the user knows and what he wants to know, and what his level of perception is.

The second part of the MO – The intermediate phase of the call

- Make the users aware of their real problems
- Find out and share the goal
- Offer customized informations, considering that every piece of information will be touching emotionally the users
- Let them ask about anything, any questions or doubts
- Answer one question at a time, using a clear and easy language, avoiding difficult words
- Verify the implications of your actions, emotionally and cognitively
- Focus on the emotions and try to understand them
- Propose and agree on the solutions.

The third part of the MO – The final phase of the call

- Summarize what you found out about the call
- Verify that the persons have understood what you said in the call including a possible appointment in the structure
- Let them know you are available
- Greet them.

- operators' awareness of their skills in the communication process and in the personal way that they can have a relationship with their own communication style;

- knowledge and ability in using relationship and communication techniques that are fundamental for the creation of the relationship.

In this part you can find some abilities (self-awareness, empathy and active listening) and communication techniques (reformulations, elucidations, first person messages, investigating ability), that will help the professional relationship through the phone (12-14).

• *Self-awareness*: in order to establish efficient telephone communication, it is necessary that the operators are able to get in touch with themselves. Additionally, it is necessary they are aware of their limits, know their internal setting (values, prejudices, motivations, cultural schemes, personal experiences, emotions) and know how to distinguish themselves from others through an auto analysis. The operators have to be aware of the para-verbal language; they can transmit a message to the user. The ability of self-awareness gives the operators a way to delimit the border between the internal and external setting. The internal setting is the capacity to open themselves to others, overcoming prejudices and giving time and space to the user. In the telephone communication, the external setting is not shared, so the internal setting becomes crucial.

• *Empathy:* it gives to the operators the possibility to understand the user's experience, and it gives the operators the ability to see the user's point of view, pretending it was theirs but with the awareness that is still the user's point of view. The operators have to know how to enter the user's reference scheme. They have to accept the user's opinions even if they

do not share them and they have to focus on the situation that they are living from their mental and emotional perspective. The empathic operator cannot be mistaken for the person and if that happens, they will not be able anymore to help the user.

• *Active listening*: it is based on empathy and others' acceptance; it can activate a professional relationship and a non-judged relational mood. Knowing how to listen to requests, doubts, fears and anxiety can give the opportunity to catch the content of the communication through the telephone in the verbal and para verbal communication. The operator, by putting her/himself in a positive and welcoming mood with the user, shows an authentic interest in the user that will feel free and included without the fear of being judged. In the active listening, we can find many layers such as the contents (verbal communication) and the emotional connotation (para-verbal communication). The operators, at the same time, listen to themselves and check their personal experiences in a way that doesn't interfere with the relationship.

The operator, in order to perform a true active listening, can use the mirroring empathic method or use communications techniques such as:

• *Reformulation*: it is the act of repeating and giving back what the user said, using the same words and without adding something else. The operators will verify that they understood what the user said and, at the same time, the user will know that they are listening and that he will be free to talk more (such as: "are you saying that…" "You are telling that…").

• *Clarification:* it is the act of understanding the user's emotions and giving them back during the telephone call (para-verbal communication); this technique is useful to help the comprehension of the emotional experience of the other, because the operator underlines the feeling that the verbal communication transmits and gives it a constructive value. Clarification helps to avoid that the personal dimension of the operator (what he thinks or feels) could be confused with what happens with the user in a cognitive and emotional state or it could be used for interpretations that could carry away from the user's point of view and from what the user really wanted to say. Clarification is used to maintain a split between what the operator listens to and what this could affect the cognitive and emotional state of the user ("From the tone of your voice I think that…" "Is your silence a way to…" "Is this interruption a way to…").

• *Investigate skill*: it can give the ability to ask appropriate questions (open questions, closed questions, hypothetic questions) as a function of the specific phase of the telephone call with the user, but also in the situation brought by the user and how this situation is perceived. *Open questions* are useful in the first phase of the call; they give a possibility of long answers ("Could you give me a better explanation about…" or "Could you help me to understand what you really think?"). *Closed questions* are used in the other phases of the call, they should have short answers ("where" "who" "when"). *Hypothetic questions* can give the user the possibility of taking back space and finding out questions all by themselves, ("How do you think you could face this situation?" "Who do you think could help you").

• *First person messages*: using first person messages simplifies the split between what the operator thinks or feels and what concerns the user without having reinterpretations, always being in a welcoming mood. It is a very important process because it recognizes the decision of the user ("I think that...").

To use the MO, it is fundamental to train the social health professionals in a telephone communication environment. This training aims to give customized informations and stimulate the activation of empowerment processes in the population or specific target. Appropriate training gives the chance to

improve scientific skills and communication skills. It is desirable that all the operators follow standard procedures; they should be trained to give a telephone relationship in a professional, effective way. A valid training should focus on the cognitive, pragmatic and relational skills of the social health professionals and it is aimed at the learning of the basic skills of the counselling. This approach focuses on the training of the operator, that becomes as essential as the user's. The goal is to stimulate new cognitive schemes and links with the professional experience to respond to everything the user could need.

The MO allows doing surveys on the personal data, characteristics, lifestyles and behaviour that characterize those who use the telephone service. At the end of the call, it is possible to ask the user if she/he wants to participate in the research (anonymously) by answering a short survey; users are informed on the goal of the research and have to verbally give their consent. The research gives the possibility to reach people that are normally hard to reach, obtaining informations that would be ignored in a normal research. These elements are essential for the prevention. Larger researches conducted in a short amount of time and in different areas can be realized if the telephones are connected to web and share the methodology of the service, scientific contents and personal data.

Structure of a database for effective telephone communication in public health

In telephone communication, an effective bank of data and an effective administration are fundamental (15). A complete bank of data can have a double meaning: giving effective means to the operator, so helping him to give a complete information to the user and collecting information based on the users and through data sheets. In fact, it is very important the operators have data that they can communicate to the user.

Informative data are fundamental and they have to be:

• periodically updated;

• reliable, the sources where the date can be found have to be checked;

• accurate, they must have all the information necessary to address the user to other services;

• clear, because the operator needs to use them immediately;

• easily accessible, through a software that has to be shared with all of the operators.

The operator collects data during the telephone calls. It is appropriate to understand when these data can be collected without interrupting the flow of the telephone call.

The data collecting can be done anonymously if it is not planned; however, operators have to respect the privacy laws. In any case, the operator has to maintain professional secrecy during the call, similar to a live face-to-face conversation.

Data are essential to have a profile of the user that makes use of the service and their needs. The collecting has to be continuous and homogeneous and allows you to:

• quantify the telephone activity as the data represent its memory;

• address the telephone activity over time, following the variations of the users' needs;

• permit a periodic valuation of telephone activity;

• draw up updated reports, articles and documents on the telephone activity.

Both informative and statistical data are written in full or using a numeric or alphanumeric code. These data are fundamental to obtain an valuation of the telephone activity. They aim to verify if this responds to the goals or if it follows the directives of the client and whether or not it lets the operator control their professional intervention.

The storage of data is done in a structured way, using an application created to give security to mass information on internal

servers in the company or a cloud. Data can be managed through data collective form.

Data used by the operator can be stocked in full or with a code.

Every piece of information can be translated through various procedures into numeric or alphanumeric coding. In other words, "coding" is a rule that allows the representation of different information in a series of symbols (codes).

On one hand, there are various advantages of this system, such as conciseness (it contains a lot of information in short strings), the possibility to perform an electronic elaboration in real-time and the archiving of a huge amount of data in a limited space.

On the other hand, the disadvantages relate to the relinquishment of parts of the information and, in some cases, the risk that different operators may assign different coding to similar content. Finally, a restriction of the coding system is the need to store information in a sectorial manner and therefore, the opportunity to make cross-cutting links is lost.

Data collecting is a complex tool that has an interface with windows, information and drop-down menus. The telephone calls can be coded through this interface. Data give the possibility to log into a computerized data archive to give useful information on territorial services, with voluntary association to the users. Where the territorial services are connected to the telephone activity, the data allow the possibility to have a face-to-face conversation booked by the telephone service.

The structure of the form can be articulated in several sections. The first section can contain information on the internal organization of the team. The information is often automatic and does not require more work for the operator.

The second section can include information about the call, specifically from whom the user has heard about the telephone service. It is important as it permits analysis of how many other communication channels the user uses.

It is significant to comprehend if it is a new call or if the user is calling repeatedly. If the latter is the case, the operator can elaborate on the user's real needs and can direct the telephone call in a more focused way, sending the user in a territorial structure if necessary.

Other sections of the form could contain data about the user (age, sex, geographic area, nationality) and the contents of the call.

These data are related to the typology of the structure from where the telephone call is taking place. If a telephone web that deals with the same health area exists, the form can be shared contextually on the methodology of the telephone service and its scientific contents. If the telephone service is not anonymous, a further section can contain the registry of the user, the intervention (to allow other operators to know the user's activity so far) and the possible booking done through a territorial service. It also has to contain information on the user if they went to the booked appointment during the telephone call.

Evaluation of the telephone call

Data are also important for an evaluation of the telephone call.

In this context, the evaluation of the process or the result of the telephone service in public health is not addressed, despite being very important. There is some food for thought on the evaluation process of the telephone call; these are general indications to verify if the telephone call matches the goals. The evaluation can be internal (done by the operator) or external (conducted by experts that work outside the service).

In the evaluation process, both qualitative aspects (communications strategies and relationships) and quantitative aspects (number of calls, average time of the call,

number of users and their characteristics) are considered.

The internal quantitative evaluation consists in:

• collection and elaboration of data acquired during the telephone call;

• writing of reports and documents;

• analysis of costs and benefits aimed to verify the relation between the resources (economic, professional) and the ability to answer the health needs of the user in an appropriate way.

The internal qualitative evaluation consists of:

• one or more operators listening to one another to improve their performance;

• auto-observation and auto-evaluation of the same operator with the goal to make their intervention more efficient;

• team discussion of the "emblematic" cases, that allows to find new strategies based on the various situations;

• role-play simulating critical situations that can identify and share new solutions;

• a survey performed on the user at the end of the telephone intervention, aimed to perceive his degree of satisfaction.

Some aspects that characterize the quantitative and qualitative internal evaluation can be used in an external, qualitative and quantitative evaluation process; in this analysis of the costs and the benefits, a detection done with an investigation on the degree of satisfaction of the users through surveys on the telephone calls, this evaluation can be done by an independent agency.

To summarize, the qualitative and quantitative external and internal evaluation of a telephone intervention based on the counselling skills (using the MO), allows for modification or refining of the professional intervention of the operators. It quantifies the size of the work done, having a tool to monitor the users' needs and to ease the professionals to answer efficiently.

Results

The helplines of the Istituto Superiore di Sanità

The MO illustrated above, made by several helplines of the ISS as an example of correct scientific information, updated and customized on sexually transmitted infections, addictions and rare diseases (9).

National AIDS and STI Helpline

The National AIDS and STI Helpline (800 861061) is a national service, anonymous and free, situated in the "communication" area of the UO RCF of the DMI of the ISS. The service has been active for 34 years; it is active from Monday to Friday from 1 *PM* to 6 *PM*, in Italian and English.

The TV AIDS and IST have psychcologists and doctors, experts in communication, legal consultants and technical assistants of research, with scientific and communication-relationship skills.

The "National Commision against AIDS of the "Ministry of Health" created the service in 1987, at a time when AIDS was a disease with a high risk of mortality in young adults, and without an effective therapy. It was a sanitary and social emergency with a huge media impact (16, 17). Later on, the service also began to work in ISTs. Nowadays, the aim of the TV AIDS and IST is to give the users scientific information, updated and customized on HIV, AIDS and ISTs through telephone communication using counselling skills and the MO. Users can also be sent to diagnostic centres in the national territory. There is also a database with 700 sanitary structures in every Italian region where it is possible to offer screening and therapies; these are centres in hospitals and ASLs divided into regions and districts. The information on the sanitary structures with the opening time and the various tests or examinations are published on the website (www.uniticontrolaids.it) of the UO RCF. The website, created in 2013, faces the

"National AIDS and STI Helpline", using both telephone communication and digital communication.

Twice a week, the "National AIDS and STI Helpline" (Monday and Thursday from 2 PM to 6 PM) give the possibility of a legal consultation on privacy and the responsibility of the rights that people with HIV or ISTs have.

Furthermore, the experts of TV AIDS and IST on Friday from 2 to 5 PM can be reached by those who do not live in Italy using the Skype contact **uniticontrolaids**.

Prevention activities are integrated with the research on the psychological-socio-behaviour field in a formation and coordination network. Since 2008, the team of the UO RCF manages the Italian network ReTe AIDS, which includes the TV AIDS and IST and other 12 HIV/AIDS/IST services of telephone counselling in public non-governmental structures. These services are in various districts in the North, Center and South of Italy. The "ReTe AIDS" shares the scientific contents on the IST, the methodology of the telephone communication based on counselling and data entry forms with the software.

In 2018, the UO RCF and the University Ca' Foscari in Venice, with the "Ministry of Health" activated, for the first time in Italy, an email service that gives scientific information on sexually transmitted infections dedicated to deaf people. If anybody has doubts about their health or has participated in risky sexual behaviour he/she can learn more by writing an email to tvalis@iss.it. Experts of the "National AIDS and STI Helpline and IST" always answer emails ensuring privacy according to the laws.

The data of the TV AIDS and IST are published on the informative campaign of the "Ministry of Health".

From 20 June 1987 to 31 December 2020, the experts answered 811,794 calls; of these calls, 75.9% were male and in time calls from females lowered.

The most commonly found age groups in the calls are 19-30 (53.3%) and 31-40 (28.7%), the median age is 29 years old (IQR: 24-36 years). The majority of the calls are from the North West regions (30.8%) and Central Italy (28.5%). The majority of the users are people that engaged in heterosexual relationships (57.2%), followed by people that didn't have the risk of contracting an IST, but called to gain information (parents, teachers, health professionals and citizens) with a percentage of 29.7%. The total number of questions is 2,250,863 concerning the way to transmit IST (28.0%), information on medical examinations and where to take the HIV test (25.5%). Through telephone intervention, if users are at risk, they are sent to the closest diagnostic clinical centre where they will be given information about the access and the exams on every diagnosis service on the territory.

The psychological and sociological aspects concern 13.3% of the questions. Within the 12.4% of the questions, a remarkable level of disinformation is noticeable, in particular the transmission mode of HIV (Tables 1 - 2) (18).

Helpline on Addictions and Doping

The Helpline on Addictions and Doping, *in the National Centre on Addictions and Doping (*CNDD) of the Italian National Institute of Health, has a story that began in 2000 with the institution of the Quitline Smoking (TVF) – 800 554088 and the Alcohol Helpline (TVA) – 800 632000. In: 2008 the Anti-Doping Helpline (TVAD) – 800 896970 was activated, in 2009 the Drug Addiction Helpline (TVD) – 800 186070 and in 2017 the Gambling Helpline (TVNGA) – 800 558822. A team of psychologist researchers works on many topics, considering that addictions are complex and they often have other substance and behavioural addictions.

The goal of the services is to give scientific information, customized and given through a

Table 1 - National AIDS and STI Helpline from 20/06/1987 to 31/12/2020

		Number	Percentage (%)
Total calls		811,794	
Total questions		2,250,863	
Sex	Male	616,497	75.9%
	Female	194,875	24.0%
	Transexual	31	0.0%
	Non-Indicated	391	0.0%
Age groups	1-18	33,175	4.1%
	19-30	432,881	53.3%
	31-40	233,070	28.7%
	41-50	74,825	9.2%
	51-60	22,335	2.8%
	61-70	6,816	0.8%
	Above 70	1,728	0.2%
	Non available	6,964	0.9%
Percentage distribution based on territory	North-West	250,137	30.8%
	North-East	124,362	15.3%
	Centre	231,169	28.5%
	South-Islands	200,768	24.7%
	Abroad	155	0.0%
	Non Indicated	5,203	0.6%
Percentage distribution based on user groups	Heterosexual	464,610	57.2%
	NFDR (not risky factors)	241,379	29.7%
	Homosexual-bisexual	50,807	6.3%
	HIV positive	18,060	2.2%
	Drug addicted	8,149	1.0%
	Others/Non indicated	28,789	3.5%
Percentage distribution based on questions	How it is transmitted	630,762	28.0%
	Information on tests	574,489	25.5%
	Psychological and social aspects	299,240	13.3%
	Disinformation	278,854	12.4%
	Aetiological agent (Virus, bacteria...)	130,033	5.8%
	Prevention	144,522	6.4%
	Symptoms	77,508	3.4%
	Therapy and research	39,891	1.8%
	Other	75,564	3.4%

Table 2 - National AIDS and STI Helpline – Legal consulting area 2012-2020

		2012-19		2020		Total	%
Total calls		693		70		763	
Total questions		813		99		912	
Sex	Male	465	67.1	46	65.7	511	67.0
	Female	227	32.8	24	34.3	251	32.9
	Transexuals	1	0.1	0	0.0	1	0.1
Age groups	10-19	3	0.4	0	0.0	3	0.4
	20-29	69	9.9	10	14.3	79	10.3
	30-39	161	23.2	15	21.4	176	23.1
	40-49	239	34.6	19	27.1	258	33.9
	≥ 50	195	28.2	22	31.5	217	28.4
	Non-Indicated	26	3.7	4	5.7	30	3.9
Percentage distribution based on territory							
	North	319	46.0	35	50.0	354	46.4
	Centre	203	29.3	19	27.2	222	29.1
	South	130	18.8	14	20.0	144	18.9
	Islands	41	5.9	2	2.8	43	5.6
Percentage distribution based on user groups							
	HIV positive	456	65,8	53	75.7	509	66.8
	NFDR (Not risky behaviour)	177	25.5	7	10.0	184	24.1
	Heterosexuals	39	5.6	3	4.3	42	5.5
	Homosexuals and bisexuals	8	1.2	6	8.6	14	1.8
	Other	13	1.9	1	1.4	14	1.8
Percentage distribution based on questions							
	Legislation	305	37.5	39	39.5	344	37.7
	Privacy	212	26.1	16	16.2	228	2.0
	Providence/Assistance	165	20.3	20	20.2	185	20.3
	Criminal issues	46	5.7	3	3.0	49	5.4
	Sanitary defaults	47	5.8	9	9.1	56	6.1
	Discrimination	14	1.7	4	4.0	18	2.0
	Procreation legislation Medical Assistance	2	0.2	0	0.0	2	0.2
	Mobbing	4	0.5	4	4.0	8	0.9
	Other	18	2.2	4	4.0	22	2.4

telephone intervention based on counselling using the MO and to offer telephone paths (proactive and reactive counselling).

All the helplines are nationally based, they are anonymous and free and they are active from Monday to Friday from 10 *AM* to 4 *PM*. They can be reached through these emails: telefono.dipendenze@iss.it and tvdplis@iss.it (for deaf people) and they publish their initiatives through Facebook, Instagram, Twitter and YouTube of CNDD or the ISS website.

In their activity, the operators support the services on the territory dedicated to addictions, amplifying the visibility and promoting the knowledge and awareness by citizens. The national census and the update of the territorial services for the ending of

tobacco smoke (Centri antifumo-CAF) and the services for gambling addiction are two of the many activities for support. Data are published online on the "Guida ai servizi territoriali per la cessazione dal fumo di tabacco" and "Guida ai servizi e alle risorse territoriali per le problematiche legate al gioco d'azzardo".

Quitline Smoking

The Quitline Smoking (TVF) – 800 554088 created in 2000, is a counselling telephone service that deals with tobacco and nicotine smoke and it is aimed at smokers to support them in quitting, their families and ex-smokers at risk of relapse.

Over the years, the TVF team has expanded the offer of service supporting users with customized interventions with scientific evidence of the counselling for the breakdown of smoking highlighted by the Cochrane Review in 2013 (19) and reaffirmed in the research in 2019 (20) with the support of the WHO (21-23) in quit line.

The TVF was the object of various information and awareness campaigns and in the last decade, there were two legislative interventions:

Decree of the 25th October 2012 of the Ministry of Health, where 800 554088 must be put in rotation on tobacco products' labels.

Legislative Decree n. 6 of 12 January 2016, where the number must be put on every pack of cigarettes and tobacco products.

In the twenty years of activity (2nd of May 2000 – 31 December 2020) the TVF has managed 81,145 calls. The majority of the users were smokers (89%) and there were also calls from families asking for help for their relatives (5.1%). The remaining calls were from health professionals and school workers (3.9%) and ex-smokers at risk of relapsing (1%).

Users are predominantly male (M 64.3% vs F 35.7%) and age groups are mostly 51-60 (13.6%) and 41-50 (13.2%); the median age is 46 years old (IQR: 35-37 years). The calls arrived from the whole national territory, with a higher percentage in the south of Italy (25%) and in the North-west (20.8%).

The majority of users ask for support to quit smoking (92.4%), also considering failed previous attempts. More requests concern information on the Anti-smoking Centers - Centri AntiFumo – CAF (5.6%), the legislation on prohibitions, passive smoke and health risks using tobacco and nicotine (1.9%), questions for new tobacco and nicotine products are also on the rise (0.3%) (Table 3).

To respond to these requests, the team directs smokers to territorial services. This is possible thanks to the continuous update of the CAFs. To those that try to quit by themselves, the operator suggests support and self-help materials. Smokers that highlight strong motivation or that have difficulty reaching the CAF, are given the possibility to have a telephone path to help them quit.

Every telephone call is a chance for the operator to give correct legislative and sanitary information.

Alcohol Helpline

The Alcohol Helpline (TVA) – 800 632000 is a national telephone service based on counselling skills to oppose the risky and damaging use of alcoholic drinks and it is aimed at users with alcohol problems and their relatives.

In its 20 years of activity (2nd May 2000 – 31 December 2020) the TVA has managed 5,778 calls from all over the country. Those who contacted the service are 30% risky consumers (M 64% vs F 36%), 52% families of consumers (M 37% vs F 63%) and 17% of social health professionals and school workers.

Users are mainly adults fairly distributed in both sexes (F 52% vs M 48%).

The most common motivation to call the service is the desire to quit the dangerous use of alcohol and to ask for information

Table 3 - Quitline Smoking - from the 2nd of May 2000 to the 31 December 2020

		Number	Percentage (%)
Total calls		81,145	
Total questions		86,421	
Sex	Male	52,186	64.3%
	Female	28,959	35.7%
Age groups	1-18	6,897	8.5%
	19-30	10,050	12.4%
	31-40	8,241	10.2%
	41-50	10,695	13.2%
	51-60	11,023	13.6%
	61-70	7,869	9.7%
	Above 70	3,880	4.8%
	Not available	22,490	27.7%
Percentage distribution based on territory	North-west	16,871	20.8%
	North-east	8,358	10.3%
	Centre	14,593	18.0%
	South	20,301	25.0%
	Islands	9,289	11.4%
	Abroad		0.0%
	Not indicated	11,733	14.5%
Percentage distribution based on user groups	Smoker	72,207	89.0%
	Relative/friend	4,102	5.1%
	Ex-smoker	801	1.0%
	Other	3,195	3.9%
	Non indicated	840	1.0%
Percentage distribution based on questions groups	Quit smoking	74,946	92.4%
	Centres against smoke contacts	4,552	5.6%
	Information (health, therapy, legislative)	1,533	1.9%
	New generation products	239	0.3%
	Other	2,426	3.0%
	Not indicated	2,725	3.4%

on health risks and cure services in the territory.

Anti-Doping Helpline

The Anti-Doping Help Line (TVAD) – 800896970 is a national telephone service based on the basic counseling skills, through which a team of experts and psychologists provides information on the doping phenomenon and related problems, supporting and motivating the person towards healthy behaviors and lifestyle choices.

The TVAD was created in 2008 thanks to a loan from the "Sezione (ex Commissione) per la Vigilanza ed il controllo sul Doping e per la tutela della salute nelle attività sportive (SVD)" of the "Ministry of Health". In its

12 years of activity (12 August 2008 – 31 December 2020) the TVAD managed 937 calls from all over the country. Those who contacted the service are mostly adults (average age: 43 years old), 41% are sports people (M 71% vs F 29%), 46% are families of sports people (M 41% vs F 59%) and 12% are social health professionals or interested people.

The most common questions are those about the information on health risks, cure services in the territory and questions about how to manage doping.

Drug Addiction Helpline

The Drug Addiction Helpline (TVD) – 800 186070 is a national telephone service based on the basic skills of counselling. It was created in 2009 to help drug consumers and their families and to simplify the awareness to face the problematic situation linked to drugs. In recent years, with the increase in drug use, the Service has received requests for information on these unfamiliar substances and on their effects on health.

In 11 years of activity (15th April 2009 – 31 December 2020) the TVD managed 1,384 calls. Of the adults who contacted the services, 25% were consumers (M 74% vs F 26%), 69% were consumers' relatives (M 39% vs F 61%) and 6% were social health professionals. Users were mostly adults, fairly distributed in the two sexes.

Both consumers and relatives contact the TVD primarily in times of need; consumers ask operators about treatment centres and relatives generally ask how to understand if the consumer is a consumer and to what extent.

Gambling Helpline

The Gambling Helpline (TVNGA) – 800 558822 is a national service created in 2017, it is a telephone service based on the basic skills of counselling that is aimed at people that have problems linked to gambling and their families.

The importance and the potential of this tool were confirmed by the decree on 18th of September 2018 by the "Ministry of Health" where it states that it is compulsory to include the caption "telefono verde nazionale 800 55 8822 per i disturbi legati al gioco d'azzardo" (Helpline 800 558822 for gambling related disorders).

In just over 3 years of activity (02nd of October 2017 – 31 December 2020) the TVNGA managed 7,665 calls from all over the country, with most calls from the south (19.7%) and the centre (16.7%).

The service is contacted by gambling gamers (38.2%) and their families (33.3%); professional workers such as social health professionals or gambling operators represent the rest of the percentage. Users were mostly male (M 61.8% vs F 37.7%) and the median age is 44 years old (IQR: 33-55 years). The most common reasons to call the service were to quit gambling (67.4%), request information on cure services and other research in the territory (49.3%) and information concerning the legislative and economic aspects (22.8%) (Table 4).

According to the census of the dedicated territorial services, the sending to cure services, the support services and the structures in the territory, the helpline is essential. Psychological support for gamblers and their relatives is a fundamental part of our services.

In Table 4 you can find the data from the Quitline Smoking and the Gambling Helpline.

Italian National Helpline for Rare Diseases

It was created in 2008 on the rare disease awareness day (29th of February), the Italian National Helpline for Rare Disease (TVMR) – 800 896949 was strongly desired by the "Italian National Institute of Health" (ISS), from the associations of the families and the "Ministry of Health" (24). For more than 20 years, rare diseases represent a priority in European public health (25). More than 30

Table 4 - Gambling Helpline – from the 2nd of October 2017 to the 31 of December 2020

		Number	Percentage (%)
Total calls		7,665	
Total questions		10,224	
Sex	Male	4,734	61.8%
	Female	2,886	37.7%
	Not indicated	45	0.6%
Age groups	1-18	30	0.4%
	19-30	785	10.2%
	31-40	851	11.1%
	41-50	951	12.4%
	51-60	751	9.8%
	61-70	412	5.4%
	Over 70	173	2.3%
	Not available	3,712	48.4%
Percentage distribution based on territory	North-west	875	14.0%
	North-East	634	10.2%
	Centre	1,042	16.7%
	South	1,227	19.7%
	Islands	415	6.7%
	Abroad		
	Not indicated	2,046	32.8%
Percentage distribution based on users' groups	Player	2,933	38.3%
	Relative/Friend	2,556	33.3%
	Social health worker	119	1.6%
	Other	107	1.4%
	Not indicated	1,950	25.4%
Percentage distribution based on questions groups	Quit playing	4,282	67.4%
	Service information	813	12.8%
	Information about therapy	1,450	22.8%
	Requests territorial resources	3,129	49.3%
	Family and job problems	1,298	20.4%
	Other	524	8.2%
	Not indicated	206	3.2%

million European citizens and 300 million world citizens have a rare disease, even though it is difficult to obtain exact data (26).

Rare Diseases have a wide group of pathologies that share the fact that it is rare to have them (not > 5 people/10,000 in Europe and Italy) often they have a clinical and management complexity. The WHO calculated the existence of 6,000 nosology entities (8,000 including synonyms) (27-29). 80% of these diseases are led back to a genetic cause and the remaining 20% have a multifactor reason (e.g., environment or food factors).

These pathologies have chronic progress, they are often disabling and they represent

a possible cause of early mortality. These diseases have a wide heterogeneity of clinical manifestations, age of outbreak, etiopathogenesis mechanisms, organs and systems hit and a small percentage of these can count on resolute therapy strategies. In the various challenges that rare diseases patients have to live with, one of the most important ones is to face the fact that we do not have enough knowledge and information to raise awareness and to sensitize citizens on these topics like research, pharmacological experimentation, new diagnostic tools and prevention (30).

The TVMR has the goal to offer a national tool based on telephone intervention using basic skills of counselling. This information has to be easily accessible. The service is collocated and integrated into the "Centro Nazionale Malattie Rare" (31) of the ISS, and a team of psychological researchers with specific communication-relationship skills manages it. The team uses also the back-end support of a doctor consultant. The helpline is active from Monday to Friday from 9 *AM* to 1 *PM*, it is free both for mobile and landline phones. It is possible to contact them via email at: tvmrlis@iss.it (for deaf people) and tvmr@iss.it, also reachable from abroad.

The TMVR, respecting privacy laws, uses specific computerized forms to save data, in these forms, there is information strictly necessary to form the answer that can be given during the call or concerning the complexity of the question.

In 13 years of activity (10th March 2008 – 31 December 2020) the service has received 32,576 calls and answered 51,000 questions. 67% of the calls were made by women. Users calling TVMR are: patients (49%), relatives (34%), especially parents or partners; social health professionals (9%), friends or acquaintances (2%) and associations of patients (1.6%). The remaining 4% are students, professionals and citizens.

The distribution by age groups highlights that people aged 31-60 years old with a median class of 41-50 years old contact the telephone service. There are no users below 18 years old.

Contact to the service is made in the Italian territory with a higher percentage in the Centre (28%) and the South (24%); there are fewer contacts from abroad (0.3%) even though this has been rising in the last few years because there is a European directive for trans-border cures. There is also an institution of the reference European web for rare diseases (ERN) in collaboration with the "Ministry of Health".

The majority of the requests concern one or more patients (in 60% of the female cases). The more significant age group in patients is below 18 years old, and they represent 44%, followed by 41-50 (13%), over 60 (12%) and finally ages 31-40 and 51-60 which make up 11%. Only 9% of young adult users are under 30. It highlights that in 17% of calls, the questions do not concern the patient but general topics on rare diseases.

The overall analysis of the questions is that 69% of the needs are about the sociological-assistance (31%) and rights (38%). 59.6% of the users need an orientation on the territory, in particular towards expert centres of rare diseases, national wise (Rete Nazionale Malattie Rare) and international wise (ERN). Moreover, there are questions on more clinical topics (19%) and some of them are motivated by the research of confirmation of the diagnosis or the long research for the first diagnosis (Table 5).

The ultimate goal of the TVMR, in the various initiatives and activities, is to ease the path that a person with a rare disease and their family have to face during their life. This is possible thanks to networking actions with all the people involved, in particular with the regional coordination and their information counter with whom the TVMR interacts and collaborates. The TVMR promoted the "Rete Italiana Centri di Ascolto e Informazione sulle Malattie

Table 5 - National Helpline for Rare diseases from 10/03/2008 to 31/12/2020

		Number	Percentage (%)
Total calls		32,576	
Total questions		51,093	
Sex	Male	21,795	66.9
	Female	10,435	32.0
	Not indicated	346	1.1
Age groups	1-18	29	0.1
	19-30	1,441	4.4
	31-40	4,084	12.5
	41-50	5,578	17.1
	51-60	4,310	13.2
	61-70	2,495	7.7
	Over 70	1,021	3.1
	Not available	13,618	41.8
Percentage distribution based on territory	North-West	5,859	18.0
	North-East	4,279	13.1
	Centre	9,177	28.2
	South	7,743	23,8
	Islands	3,679	11.3
	Abroad	85	0.3
	Not indicated	1,754	5.4
Percentage distribution based on users' groups	Patient	15,940	48.9
	Relative	10,981	33.7
	Health professionals	3,011	9.2
	Friend	653	2.0
	Association	523	1.6
	Social professionals	91	0.3
	Institution	225	0.7
	Student	51	0.2
	Journalist	21	0.1
	Other/not indicated	1,080	3.3

(segue Tab. 5)

(segue Tab. 5)

Percentage distributions based on questions groups			Percentage distribution of the questions' topic	Interest (in %) of the user to singular topic
	Centres of Expertise (at national and international level) and health local services	15,802	3.9	48.5
	Social and care welfare benefits	19,419	38.0	59.6
	Clinical, genetics and psychological counselling	6,263	12.3	19.2
	Treatment, clinical trials and orphan drugs	2,322	4.5	7.1
	Patient's organizations	1,490	2.9	4.6
	Public health and patients care problems and complains	1,243	2.4	3.8
	Various	4,121	8.1	12.7
	Contacts of other public institutions	270	0.5	0.8
	RDs Registries	163	0.3	0.5

RarE (R.I.C.A.Ma.Re)" to reinforce the informative exchange and improve citizens' support. With the same goal, the service from 2012 is a member of the European Network of Rare Disease Helplines, coordinated by the Eurordis, the European federation for rare diseases.

Lastly, the experts of the TVMR manage to update the institutional database on www.malattierare.gov.it promoted by the "Ministry of Health" in collaboration with the ISS. The website is active since 2020, it is interfaced with the TVMR integrating telephone communication with digital communication and it was created to give information to citizens on rare diseases concerning referring structures, rights and the path on national and international services.

Conclusion

Communication for health is considered a strategy and a fundamental part of having a prevention policy and promoting health. Since public health is crucial, institutions must take care of solid communication initiatives with a clear vision of the target, the means and the criteria to evaluate. In this field, the attention is on telephone intervention that is structured using basic counselling skills and part of the MO, employed by the Helplines of the ISS that integrates with the other institutional informative sources (websites, social networks etc.). This intervention concerns elective settings where it is necessary to welcome, listen to and provide updated information that is clear and customized, activates empowerment processes and can send users to other references in public health.

These characteristics can ease the implementation of the MO in other countries, independently from organized patterns in public health and specific sociological and cultural characteristics.

Telephone interaction is corresponding to the users' requests, because it can lead

to efficient communication and listening to real health needs to establish a customized professional relationship and give answers without judgement of values and imposition, easing users' awareness to face their problems.

ISS' telephone services have demonstrated in the years that the services are privileged observers and monitoring points to evaluate in time the possible changes of the informative needs concerning different health topics and changing approaches for different population groups. This can allow protection strategy, health promotion and effective preventive intervention. This evaluation is extremely relevant where people, belonging to difficult groups, are involved because they risk being excluded from the prevention programs and health promotion paths.

To summarize, the MO represents a reference protocol to give efficient and punctual answers to a health request from citizens and it applies to various fields.

The MO prepared by the UO RCF is proposed as a communicative-relational reference protocol for the first-level telephones in the SARS-CoV-2 pandemic (9).

It is important to remember that the methodological formulation of the MO has been elaborated concerning the principles and recommendations of the WHO given in 1989 through the Global Program on AIDS (8). These recommendations highlight that in the counselling intervention we have to consider the distinction between basic counselling skills and counselling prevention, as a specific professional activity that requests a specific formation. It is also important to pay attention to not reinterpret these skills with a generic kind attitude (befriending) or with generic advice that does not expect a comparison between points of view and people's values with their decisional capacity (8, 32). It is also fundamental to highlight that the structure of the MO is founded on solid theoretical bases, and this can be useful to all of the social health operators that use the telephone as the main communication tool with citizens. Even though they have different goals, this can be also shared outside of the national borders.

It is useful to highlight that to have an efficient application of the MO, a formation of the social health professionals that work in a telephone communication service is necessary. This formation has to be characterized by the integration of the knowledge and technical-scientific skills of the sanitary context where the telephone service is located.

It is necessary to remember that the formative paths should have a dedicated space to delve into the elements that characterize the availability and motivation of every professional to be in the relationship with an attitude that must be empathetic and focused on emotions and reactions.

Author's Contribution:
AML, AC, PG, BD, LM, RP, MD, DT drafted the manuscript. PG; LM, MD analyzed data. AC, PG contributed to data interpretation on National AIDS and STI Helpline. LM contributed to data interpretation on Helpline at National Centre on Addictions and Doping. MD contributed to data interpretation on National Helpline for Rare. BD analyzed the role of the telephone in public health communication. AML, AC, PG, CG contributed to revised the manuscript for intellectual content.

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Riassunto

Il Modello Operativo Comunicativo-Relazionale dell'Istituto Superiore di Sanità per un intervento telefonico efficace in sanità pubblica, strutturato secondo le competenze di base del counselling

Introduzione. In sanità pubblica la comunicazione ha un ruolo cruciale in quanto diventa componente integrante degli interventi di prevenzione, nonché strumento proattivo per la promozione della salute In un'ottica di pianificazione delle iniziative di comunicazione è opportuno ricorrere a mezzi di comunicazione che possano favorire il processo comunicativo bidirezionale, come la comunicazione faccia a faccia e la comunicazione telefonica.

Materiali e metodi. In riferimento a quest'ultima, l'Istituto Superiore di Sanità ha sviluppato il Modello Operativo Comunicativo-Relazionale, basato sulle competenze di base del counselling, per fornire agli operatori sanitari un protocollo di riferimento, strutturato e replicabile, che possa consentire ai diversi professionisti della salute di attuare attraverso l'acquisizione e l'integrazione di competenze tecnico-scientifiche e comunicativo-relazionali, una comunicazione telefonica efficace con la persona-utente. Il fine è quello di rispondere in modo personalizzato ai diversi bisogni di salute espressi.

Il Modello Operativo è stato messo a punto dagli esperti del Telefono Verde AIDS e Infezioni Sessualmente Trasmesse, Servizio collocato all'interno dell'Unità Operativa Ricerca Psico-Socio-Comportamentale, Comunicazione, Formazione del Dipartimento Malattie Infettive. Successivamente tale Modello Operativo è stato proposto anche agli esperti dei Telefoni Verdi del Centro Nazionale Dipendenze e Doping e del Telefono Verde del Centro Nazionale Malattie Rare dell'Istitituto Superiore di Sanità, che lo hanno recepito ed integrato nel loro approccio telefonico.

Risultati. Il Modello Operativo sopra illustrato ha consentito alle diverse linee telefoniche dell'Istituto Superiore di Sanità di fornire una corretta informazione scientifica, aggiornata e personalizzata su infezioni sessualmente trasmissibili, sulle dipendenze e sulle malattie rare.

Conclusioni. Questo articolo intende illustrare il Modello Operativo e fornire i presupposti teorici che lo sottendono e la sua possibile applicazione all'interno delle differenti strutture impegnate in sanità pubblica, che utilizzino anche il telefono per una relazione professionale efficace con gli utenti.

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