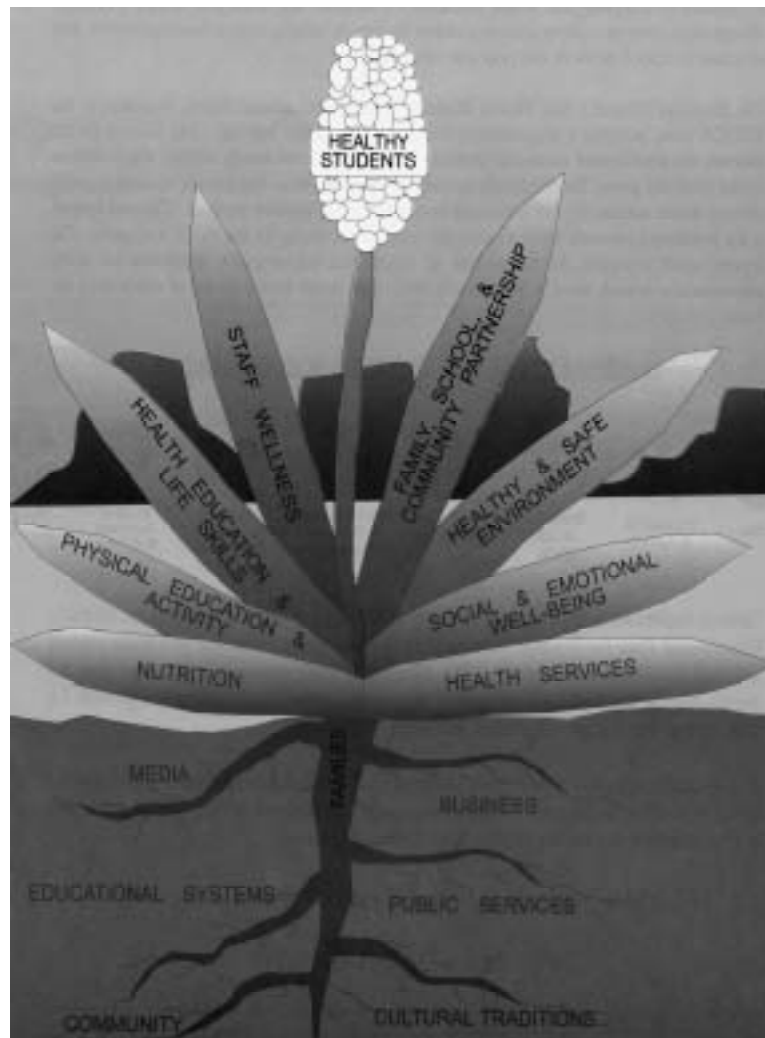


NEW MEXICO 2000 MIDDLE SCHOOL YOUTH RISK BEHAVIOR SURVEY



REPORT OF STATE RESULTS

New Mexico State Board of Education

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EXECUTIVE SUMMARY

In the spring of 2000, New Mexico participated in the Youth Risk Behavior Survey (YRBS) for middle school students. This YRBS was based on the instrument developed by the Centers for Disease Control and Prevention to 1) focus attention on specific behaviors among youth that cause the most prevalent health problems, 2) measure the changes in those behaviors over time, and 3) provide comparable state and national data. The survey focuses on health risk behaviors which relate most directly to health outcomes.

The YRBS measures six health risk behavior categories which are known to cause premature morbidity and mortality among youth:

Behaviors that result in intentional and unintentional injuries

- ◆ 51% of respondents from the 2000 survey have ridden in a car driven by someone who had been drinking alcohol.
- ◆ 67.8% of these respondents reported wearing seatbelts all or most of the time.

Tobacco use

- ◆ 42.1% of these respondents reported they have never smoked a whole cigarette.
- ◆ 20% were 10 years old or younger when they first smoked a cigarette.
- ◆ 79% said they had not smoked a cigarette at all in the 30 days prior to the survey.

Alcohol and other drug use

- ◆ 30.4% of these respondents had their first drink of alcohol at age 10 or younger.
- ◆ 10.3% had tried marijuana for the first time at age 10 or younger.

Sexual behaviors that result in and contribute to sexually transmitted diseases, including HIV infection and unintended pregnancies

- ◆ 23.1% of these respondents reported having had sexual intercourse.
- ◆ 23% reported using a condom the last time they had sexual intercourse.
- ◆ 6.2% reported first having sexual intercourse at age 10 or younger.

Inadequate dietary behaviors that result in health problems

- ◆ 6.2% of female respondents perceive themselves to be overweight, but only 5.2% of them fall in the 95th percentile of the Body Mass Index parameters for actually being overweight.
- ◆ Most females (73.6%) exercise to lose weight; 11.5% reported having vomited or used laxatives to lose weight.

Inadequate physical activity that result in illnesses

- ◆ 72.3% of these respondents said they had done strenuous exercise on three or more days of the week prior to the survey.
- ◆ 41.3% attend physical education classes less than 3 days in an average school week.
- ◆ 44.7% watch three or more hours of television on an average school day.

Information obtained through the New Mexico YRBS will be used by the state, counties, and local communities as they plan services, activities and programs for the youth in their communities. This report is a summary of state-wide data. County-level data was also reported and is available through the Department of Health. In addition, 44 school districts requested and were provided district-specific data. District-specific data can only be released by the local school district.

INTRODUCTION

SURVEY

The New Mexico 2000 Middle School Youth Risk Behavior Survey (YRBS) was administered to public middle schools in the spring of 2000. The 50 core questions of the survey were written by the Centers for Disease Control and Prevention (CDC) to find out about behaviors of young people in eight key areas of behavior that increase the risk of death and illness.

In 2000, the same 30 questions that were added to the 1999 high school instrument—10 additional demographic questions and 20 questions about perceptions of norms regarding substance use—were added to the core CDC middle school instrument.¹

As in 1999 for the high school survey, school district superintendents were offered district-specific results.

SAMPLING DESIGN

The frame consisted of all public middle and junior high schools in New Mexico, grades 6 through 8, excluding K-6-only schools. It was felt that the logistics of sampling from only one grade in a school would be too cumbersome for the schools and teachers in those schools.

Samples were drawn at the district level for those districts that had requested district-specific results. The samples within the district were stratified by 2nd period classroom and drawn according to an equal probability sampling formula. Because the school districts self-selected and were not drawn according to a probability design, results from the district level cannot be aggregated to make inferences at the state level.

There were approximately 64,400 total students eligible (in grades 6-8) from 163 middle schools in all 89 districts. The 52 participating districts provided a pool of 27,750 eligible students in 86 schools out of which the desired sample size was 8,032.

RESPONSE RATE

The response rates are computed using the minimal desired sample size after increasing for absences/refusals and actual classroom enrollment divided by the usable scanned surveys. Some answer sheets had no answers on them, just codes and age, grade, and gender. Other had answers but no age, grade, or gender, which would result in missing values in the tables of the results provided to the districts. After scanning, logical edits were applied to the cases according to the criteria in the Height, Weight and BMI document obtained from Westat. (See Appendix.)

For example, a district with 1,166 students would have a desired sample size of 299. Increasing by 15% brings it up to 344. After applying the sampling interval, the classrooms selected had an actual enrollment of 383, which would be the number of surveys sent. If 296 surveys were returned and 289 were usable, the response rate for the district would be 97% (289 divided by 299). See Appendix for a detailed description of the sampling design.

52 of New Mexico's 89 school districts requested district-specific results; of that 52, 44 returned surveys for a district response rate of 85% (or 49% of all possible districts). Of that 44, 35 had a response rate of 70% or better within their districts. Those districts with 70-80% response rate can, cautiously, generalize their results to their population of middle school students. Districts with more than 80% response can generalize to their middle school population with more certainty.

Several large school districts did not participate or had a low response rate. There were 86 eligible schools in the 52 districts that requested district-specific results, of which 66 responded for a school response rate of 76.7% (or 40% of all possible schools).

Approximately 15% of all surveys had to be eliminated due to no answers or logical edits. Out of 10,898 surveys sent out, 6,622 were returned, out of which 5,641 were usable. This is a student response rate of 70.2% (calculated on the minimal desired sample size of 8,032 for the aggregated district populations).

The Overall Response Rate (school response rate X student response rate) for schools selected in the district samples was 53.9%. Because of the lack of participation of large school districts and low Overall Response Rate, and the sampling design, New Mexico's results do not meet the criteria for weighting as defined by Westat. Generalizations about behaviors of young people cannot be made at the state level. The results in this report are for all respondents aggregated from district-level samples. The results pertain to respondents from participating districts and schools only, and inferences to all New Mexico public high school students should not be made.

COMPARISONS

This is the first time a middle school YRBS has been done in New Mexico. CDC does not collect national YRBS data at the middle school level, so national comparisons cannot be made.

DEMOGRAPHIC INFORMATION

Gender. The ratio of males to females in the sample is equal. This is very close to the gender representation in the total school population. In the school year 1999-2000, the percentage of males and females was 51.4% and 48.6% respectively.

Ethnicity/race. There is about the same percentage of Hispanics in this sample as was in the total student enrollment for the 1999-2000 school year (49.3%); a larger percentage if the Multiple Hispanic category is added (6.3%). The percentage of Anglos and American Indians is lower in the sample than in the total school population as reported in school year 1999-2000, which was 35.7% Anglo and 11% American Indian.

| 2000 YRBS MIDDLE SCHOOL RESPONDENT DEMOGRAPHIC INFORMATION | |
|--|---|
| Gender | 51.4% female 48.2% male |
| Ethnicity/race | 48.2% Hispanic 29% Anglo 6.3% Multiple Hispanic 5.9% American Indian 2.3% Multiple Non-Hispanic 1.4% Other 1.3% Black |
| Age | 10 or younger--.2% 11--5.7% 12--23.4% 13--37% 14--28.5% 15--4.5% 16 and older--.7% |
| Grade | 6th--21.6% 7th--38.1% 8th--37.7% Other or ungraded--1.5% |
| Language other than English | No other language at home--43.7% Half of the time or less--37% More than half or all of the time--17.3% |
| Born in US | Born in US--89.6% Moved to US 10+ years ago--4.1% Moved to US 5-10 years ago--2.6% Moved to US less than 5 years ago--1.5% |
| Grades | As and Bs--46.5% Bs and Cs--32% Cs and Ds--13.5% Ds and Fs--4.8% |
| Family have enough for things they need? | All of the time--68.1% Most of the time--22.2% Some of the time--5.8% Almost never--1.7% |
| Phone service | Local and long distance--79% Local service only--14% No phone service--6.5% |

PERSONAL SAFETY AND VIOLENCE-RELATED BEHAVIORS

In 1997, 146,400 persons in the United States died from injuries due to a variety of causes such as motor vehicle crashes, firearms, poisonings, suffocations, falls, fires, and drownings. ... One death out of every 17 in the United States results from injury. Of these deaths, 63 percent are classified as unintentional and 34 percent as intentional. Unintentional injury deaths include approximately 42,000 resulting from motor vehicle crashes per year. In 1997, injuries accounted for 20 percent more years of potential life lost (YPLL) than cancer did (1,990 per 100,000 compared to 1,500 per 100,000).

Injuries cause more than two out of five deaths (43 percent) of children aged 1 through 4 years and result in four times the number of deaths due to birth defects, the second leading cause of death for this age group.

Violence claims the lives of many of the Nation's young persons and threatens the health and well-being of many persons of all ages in the United States. On an average day in America, 53 persons die from homicide, and a minimum of 18,000 persons survive interpersonal assaults, 84 persons complete suicide, and as many as 3,000 persons attempt suicide.[10] (See Focus Area 18. Mental Health and Mental Disorders.)

While every person is at risk for injury, some groups appear to experience certain types of injuries more frequently. American Indians or Alaska Natives have disproportionately higher death rates from motor vehicle crashes, residential fires, and drownings. In addition, their death rates are about 1.75 times higher than the death rate for the overall U.S. population. Higher death rates from unintentional injury also occur among African Americans.

U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000. Online at <http://www.health.gov/healthypeople/>

In New Mexico, motor vehicle accidents are 76.5% of all accidents leading to death of 15-24 year olds. In this age range in New Mexico, accidents are the leading cause of death, suicide is second, and homicide is third.

1997 New Mexico Selected Health Statistics, published by New Mexico Vital Records and Health Statistics, Department of Health.

Question rationale: Use of seat belts is estimated to reduce the risk of a fatal motor vehicle injury by 45% and moderate to critical injuries by 50%.⁵ Motor vehicle crash injuries are the leading cause of death among youth aged 15-24 in the United States.⁶

#7. How often do you wear a seatbelt when riding in a car?

Results: 67.8% reported wearing their seatbelts always or most of the time; 12.5% said they wear seatbelts never or rarely.

Question rationale: Head injury is the leading cause of death in motorcycle and bicycle crashes.^{1,2} Unhelmeted motorcyclists are more likely to incur a fatal head injury and three times more likely to incur a nonfatal head injury than helmeted riders.³ Bicycle helmets substantially reduce the risk for serious head injuries during bicycle-related crashes.⁴

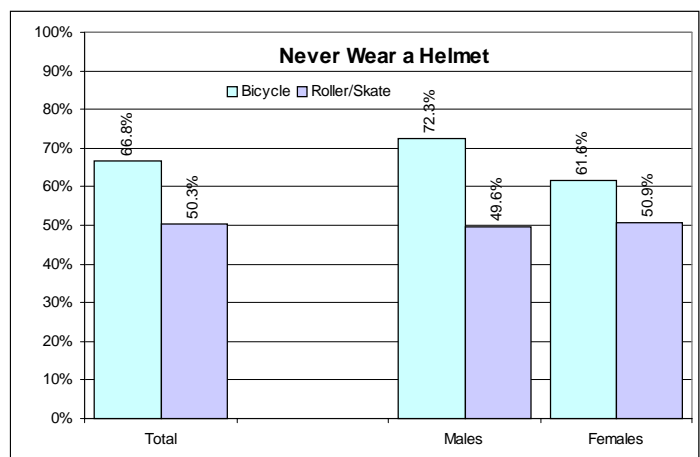
#8. When you ride a bicycle, how often do you wear a helmet?

Results: 78.1% of girls and 88.2% of boys were bike riders (determined from those that answered they don't ride a bike). 72.3% of boys and 61.6% of girls reported never wearing a helmet when riding a bicycle.

#9. When you rollerblade or ride a skateboard, how often do you wear a helmet?

There was minimal difference between boys and girls on this question: 63% of both boys and girls rollerblade or ride a skateboard (37% said they do not ride). 50% of both boys and girls reported they never wear a helmet when rollerblading or skateboarding.

Rollerbladers and skateboarders wear helmets more than bicycle riders do among these respondents.



Question rationale: Approximately 30% of all motor vehicle crashes that result in injury involve alcohol,⁷ and motor vehicle crashes are the leading cause of death among youth aged 15-24 in the United States.⁶ The percentage of fatalities and injuries that occur in alcohol-involved motor vehicle crashes is 41% and 20%, respectively.⁸

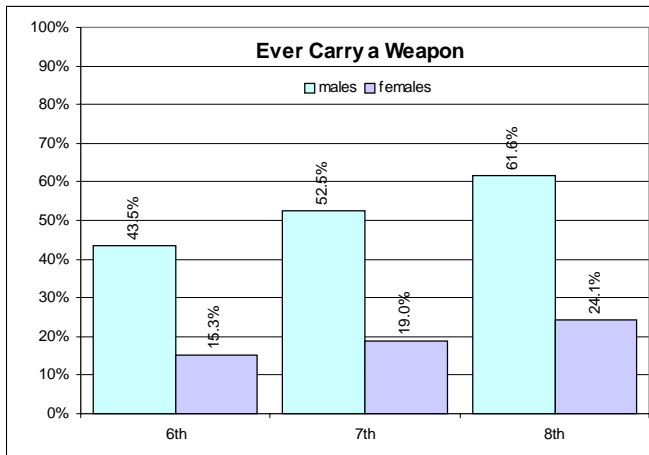
#10. Have you ever ridden in a car driven by someone who had been drinking alcohol?

There is not much difference between boys and girls on this question: 51% of all respondents answered yes; 14% answered they were not sure. The percentage that answered yes does increase by grade: 40.2% in 6th, 49.3% in 7th, and 57.9% in 8th. One reason for the increase may be that as they get older, the students are more likely to have friends that drive a car.

Question rationale: Approximately nine out of ten homicide victims in the United States are killed with a weapon of some type, such as a gun, knife, or club.⁹ Homicide is the second leading cause of death among all youth aged 15-24 (20.3 per 100,000) and is the leading cause of death among black youth aged 15-24 (74.4 per 100,000).⁶ During adolescence, homicide rates increase substantially from a negligible rate of 1.5 per 100,000 in youth aged 5-14 to 20.3 per 100,000 in

The footnote numbers in this text are references for the YRBS Item Rationale for the 1999 Questionnaire. The full list of references are at the end of this document. The full text for the most recent item rationale can be found online at <http://www.cdc.gov/nccdphp/dash/yrbhs/index.htm>

youth aged 15-24.¹⁰ Firearms markedly elevate the severity of the health consequences of violent behavior.¹¹ Firearm-related homicide and firearm-related suicide accounted for 44% and 51%,



respectively, of all firearm injury deaths in 1995.¹⁰ Unintentional firearm-related fatalities also are a critical problem among children and young adults in the United States.¹⁰

#11. Have you ever carried a weapon, such as a gun, knife, or club? (This does not include carrying these items for hunting.)

There is a big difference between boys and girls on this question: 53.8% of boys and 20.4% of girls answered yes to carrying weapon. The percentage also increases with

grade: 29% of 6th graders, 35.3% of 7th, and 42.1% of 8th. The graph illustrates that the percentage of boys in this population that carry guns increases significantly by grade.

Question rationale: Physical fighting is an antecedent for many fatal and nonfatal injuries.¹⁴ During 1996-97, nearly 200,000 fights or physical attacks occurred at schools.¹²

#12. Have you ever been in a physical fight?

#13. Have you ever been in a physical fight in which you were hurt and had to be treated by a doctor or nurse?

60.5% of all respondents answered yes to being in a fight: 75.4% of boys, and a surprising 46.5% of girls. The percentage increases with grade from 55.2% in 6th grade to 64% in 8th grade. However, only 10% of boys and 4.3% of girls said they had ever sustained an injury in a fight requiring medical treatment.

Factoid: Most of the risk factors identified do not appear to have a strong biological basis. Instead, it is theorized, they result from social learning or the combination of social learning and biological processes. This means that violent youths who have violent parents are far more likely to have modeled their behavior on their parents' behavior-to have learned violent behavior from them-than simply to have inherited it from them. Likewise, society's differing expectations of boys and girls-expecting boys to be more aggressive [*competitive*], for example-can result in learned behaviors that increase or decrease the risk of violence.

<http://www.surgeongeneral.gov/library/youthviolence/chapter4/sec1.html>

SAD FEELINGS AND SUICIDE

Mental health is fundamental to health. The qualities of mental health are essential to leading a healthy life. Americans assign high priority to preventing disease and promoting personal well-being and public health; so too must we assign priority to the task of promoting mental health and preventing mental disorders.

Disorders of anxiety and mood are characterized by the repeated experience of intense internal or emotional distress over a period of months or years. Feelings associated with these conditions may be those of unreasonable fear and anxiety, lasting depression, low self-esteem, or worthlessness. Syndromes of depression and anxiety very commonly co-occur in children.

Population studies show that at any one time between 10 and 15 percent of the child and adolescent population has some symptoms of depression. The prevalence of the full-fledged diagnosis of major depression among all children ages 9 to 17 has been estimated at 5 percent. Estimates of 1-year prevalence in children range from 0.4 and 2.5 percent and in adolescents, considerably higher (in some studies, as high as 8.3 percent). For purposes of comparison, 1-year prevalence in adults is about 5.3 percent.

Both major depressive disorder and dysthymic disorder are inevitably associated with personal distress, and if they last a long time or occur repeatedly, they can lead to a circumscribed life with fewer friends and sources of support, more stress, and missed educational and job opportunities. In a 10- to 15-year followup study of 73 adolescents diagnosed with major depression, 7 percent of the adolescents had committed suicide sometime later. The depressed adolescents were five times more likely to have attempted suicide as well, compared with a control group of age peers without depression.

Risk factors for developing a mental disorder or experiencing problems in social-emotional development include prenatal damage from exposure to alcohol, illegal drugs, and tobacco; low birth weight; difficult temperament or an inherited predisposition to a mental disorder; external risk factors such as poverty, deprivation, abuse and neglect; unsatisfactory relationships; parental mental health disorder; or exposure to traumatic events.

U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General-Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Online at www.surgeongeneral.gov/library/mentalhealth/

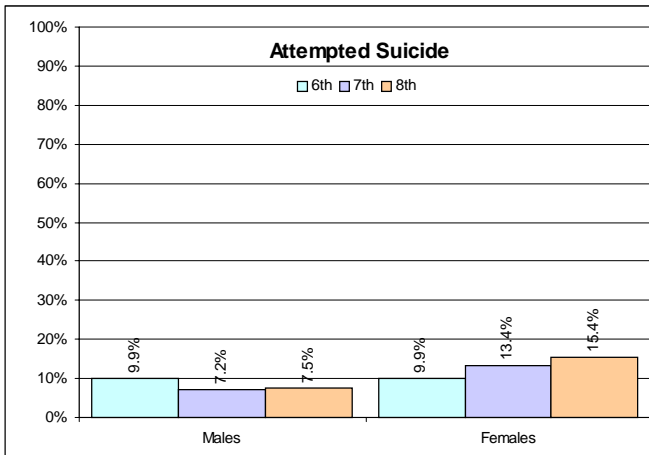
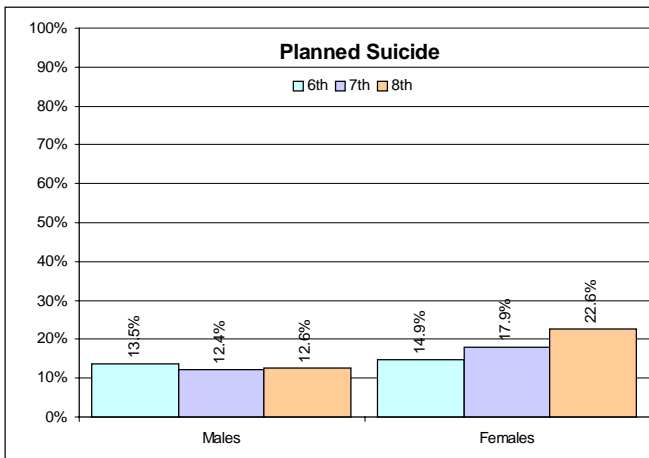
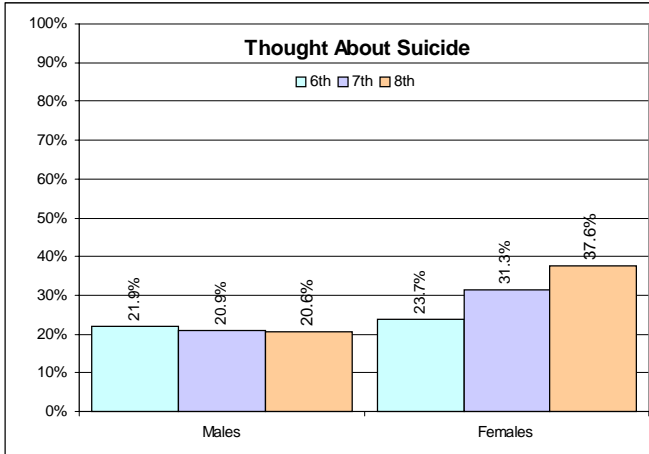
Question rationale: Suicide is the third leading cause of death among youth aged 15-24 and the second leading cause of death among white youth aged 15-24.⁶ The suicide rate for persons aged 15-24 has tripled since 1950, and in 1995 was 13.3 per 100,000.^{6,20}

#14. Have you ever seriously thought about killing yourself?

#15. Have you ever made a plan about how you would kill yourself?

#16. Have you ever tried to kill yourself.

There is a substantial difference between girls and boys on these three questions, with girls answering yes in a higher percentage on all three, and the percentage increases with grade. The percentage decreases as the severity increases: more respondents ideate than plan, and more plan than attempt.



Factoid: As of 1997, suicide is the 3rd leading cause of death for adolescents and young adults ages 15-24, and 6th ranked cause of death for 5-14 year olds.
CDC Monthly Vital Statistics Report, Vol. 47, No. 19, online at www.cdc.gov/nchs/fastats/suicide.htm

Factoid: In New Mexico, as of 1997, suicide is the 2nd leading cause of death for adolescents and young adults of all races ages 15-24 at 21/100,000 population, and 3rd ranked cause of death for 5-14 year olds at 1.6/100,000.
1997 New Mexico Selected Health Statistics, published by New Mexico Vital Records and Health Statistics, Department of Health

TOBACCO USE

Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year in the United States than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires-combined.

In 1999, 35 percent of adolescents were current cigarette smokers. In 1998, 24 percent of adults were current cigarette smokers.

Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases-all leading causes of death. Smoking during pregnancy can result in miscarriages, premature delivery, and sudden infant death syndrome. Other health effects of smoking result from injuries and environmental damage caused by fires.

Environmental tobacco smoke (ETS) increases the risk of heart disease and significant lung conditions, especially asthma and bronchitis in children. ETS is responsible for an estimated 3,000 lung cancer deaths each year among adult nonsmokers.

Adolescents. Overall, the percentage of adolescents in grades 9 through 12 who smoked in the past month increased in the 1990s. Every day, an estimated 3,000 young persons start smoking. These trends are disturbing because the vast majority of adult smokers tried their first cigarette before age 18 years; more than half of adult smokers became daily smokers before this same age. Almost half of adolescents who continue smoking regularly will die eventually from a smoking-related illness.

Adolescents. Adolescent rates of cigarette smoking have increased in the 1990s among white, African American, and Hispanic high school students after years of declining rates during the 1970s and 1980s. In 1999, 39 percent of white high school students currently smoked cigarettes compared with 33 percent for Hispanics and 20 percent for African Americans. Among African Americans in 1999, only 19 percent of high school girls, compared with 22 percent of boys, currently smoked cigarettes.

Adults. Low-income adults are more likely to smoke than are high-income adults. The percentage of people aged 25 years and older with less than 12 years of education who are current smokers is nearly three times that for persons with 16 or more years of education.

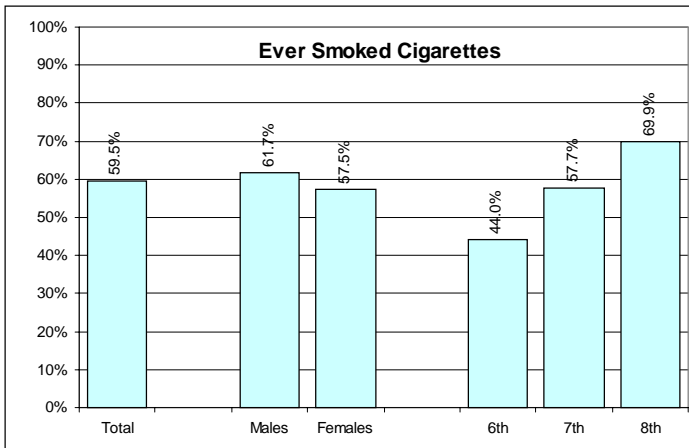
U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000. Online at <http://www.health.gov/healthypeople>

Question rationale: Tobacco use is considered the chief preventable cause of death in the United States²¹ with over 20% of all deaths attributable to tobacco use.²² Cigarette smoking is responsible for heart disease; cancers of the lung, larynx, mouth, esophagus, and bladder; stroke; and chronic obstructive pulmonary disease.²¹ In addition, there is evidence that cigarette smokers are more likely to drink alcohol and use marijuana and cocaine as compared to non smokers.²¹ If current patterns of smoking behavior persist, an estimated 5 million U.S. persons who were aged 0 -17 years in 1995 could die prematurely from smoking-related illnesses.²³ In 1996, the Food and Drug Administration issued regulations to implement the 1993 law known as the “Synar Amendment” which restricts the sale and distribution of cigarettes and

smokeless tobacco to children and teenagers under age 18.²⁴ Over 80% of school districts prohibit tobacco use in the school building and on the grounds at all times.¹³

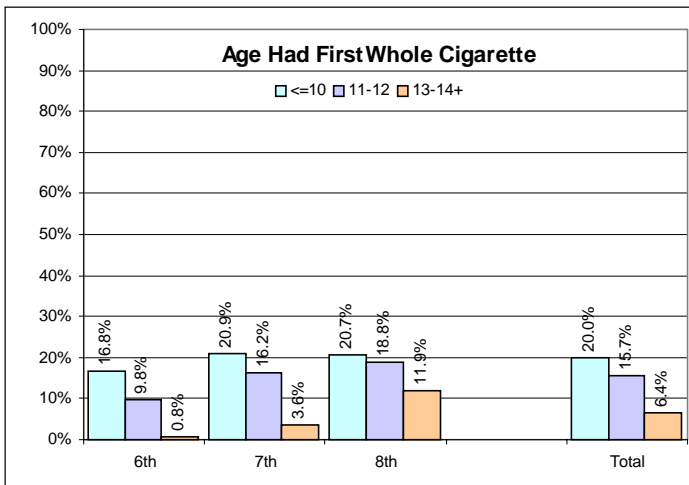
#17. Have you ever tried cigarette smoking, even one or two puffs?

Results: 59.5% of all respondents answered yes, they have tried smoking. More boys (61.7%) than girls (57.5%) have tried smoking. The percentage of students that have tried cigarettes increases steadily with grade: from 44% among 6th graders to 69.9% among 8th graders.



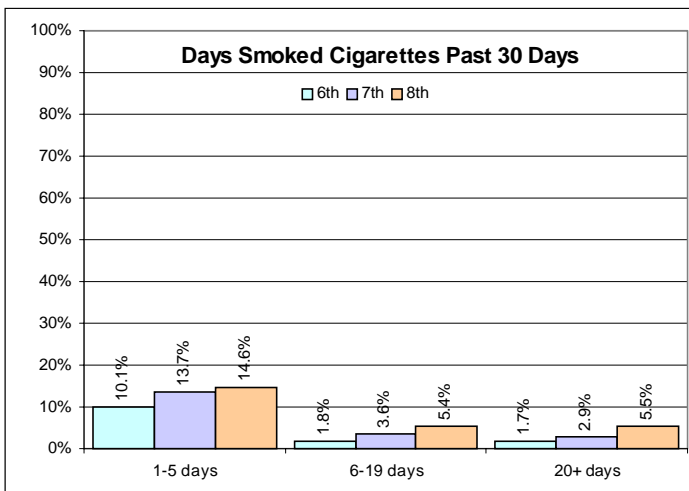
#18. How old were you when you smoked a whole cigarette for the first time?

Results: 57.9% of respondents answered they had never smoked: 73% of 6th graders, 59% of 7th graders, and 48% of 8th graders. 20% of all respondents smoked their first whole cigarette before age ten: 21.5% of boys and 18.5% of girls. Regardless of grade, most respondents had their first whole cigarette at age 10 or younger.



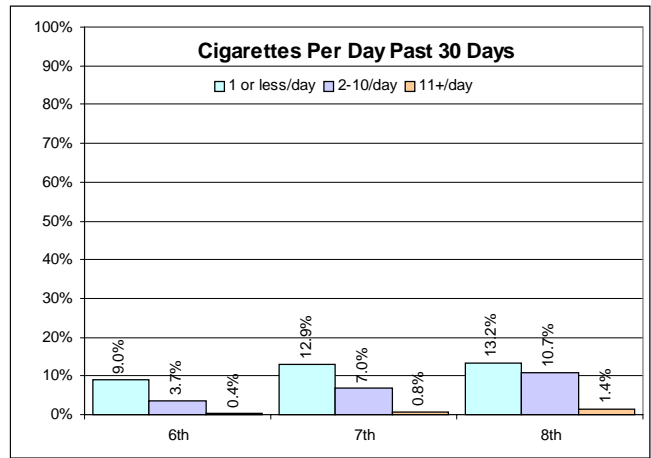
#19. During the past 30 days, on how many days did you smoke cigarettes?

Results: 79% said they did not smoke within the 30 days prior to the survey: 86.4% of 6th graders, 79.8% of 7th graders, and 79.4% of 8th graders. There is no difference between boys and girls.



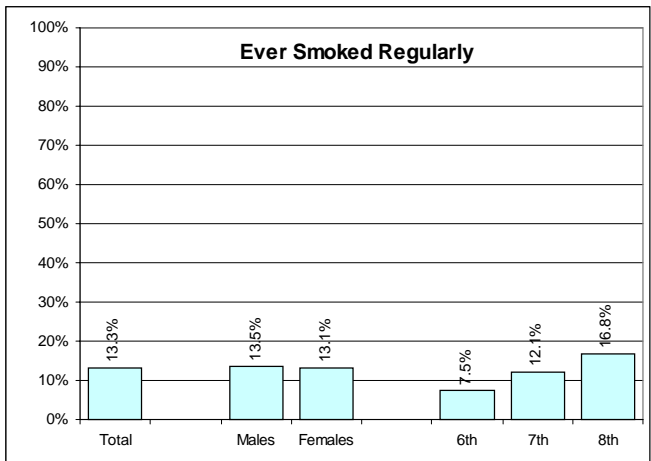
#20. During the past 30 days, on the days you smoked cigarettes, how many cigarettes did you smoke per day?

Results: 12.2% said they smoked one cigarette or less per day; 8.7% smoked 2 or more cigarettes per day. There is very little difference between girls and boys. There is a significant increase in the percentage smoking any amount as grade increases.



#23. Have you ever smoked cigarettes regularly, that is, at least one cigarette every day for 30 days?

Results: 13.3% of both boys and girls answered yes to being a regular smoker. The increase with grade is notable: 7.5% of 6th graders, 12.1% of 7th, and 16.8% of 8th answered yes to smoking regularly.

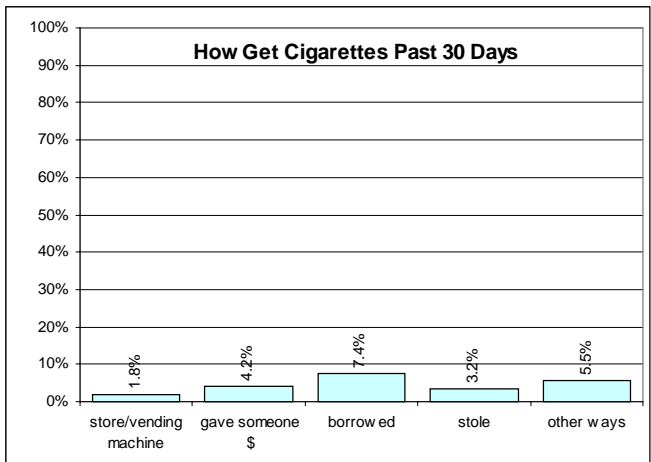


#27. If you wanted to get cigarettes, how easy would it be for you to get some?

Results: 56.1% said that it would very or sort of easy to get cigarettes.

#21. During the past 30 days, how did you usually get your own cigarettes?

Results: There is the same 78% who did not smoke during past 30 days, but out of the remainder the distribution is interesting. 1.8% of all respondents got cigarettes from a store or vending machine; 20.3% found some other way to get cigarettes.



#22. When you bought cigarettes in a store during past 30 days, were you ever asked to show proof of age?

Results: 2.0% said yes (presumably not the same 1.8% that succeeded in getting cigarettes from a store or vending machine).

#24. How wrong would most adults in your community think it was for kids your age to smoke cigarettes?

#25. How wrong do your parents feel it would be for you to smoke cigarettes?

#26. How wrong do you think it is for someone your age to smoke cigarettes?

Results: 86.2% (minimal difference between boys and girls) responded that adults in the community would think it is wrong to very wrong for kids this age to smoke cigarettes. 94.2% answered that their parents would think it is wrong for kids this age to smoke cigarettes; but a smaller percentage, 73.6% said they felt it is wrong for kids their own age to smoke cigarettes.

#28. How much do you think people risk harming themselves (physically or in other ways) if they smoke one or more packs of cigarettes per day?

Results: There is not much difference between boys and girls: 13.5% of both answered there is no to slight risk smoking one or more packs per day; 66% answered there is great risk. More 8th graders had moderate perceptions of risk than 6th graders.

Question rationale: Smokeless tobacco has been associated with leukoplakia, oral cancers, tooth and gum disease, and cardiovascular disease.²¹ Smokeless tobacco use primarily begins in early adolescence.²⁵ Cigar smoking has been associated with cancers of the oral cavity, larynx, esophagus, and lung and with chronic obstructive lung disease.²⁶

#29. During the past 30 days, on how many days did you use chewing tobacco or snuff, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?

Results: There is a moderate difference between boys and girls who answered zero days within past 30 day use: 96.6% of girls and 87% of boys. Of the boys, 7.8% reported use 1-5 days, 2.7% reported use 6-19 days, and 2.4% reported use 20 or more days.

#30. How old were you when you first used chewing tobacco or snuff?

Results: 83.9% of all respondents reported they'd never used chewing tobacco or snuff, with not much difference between boys and girls. 9.0% first tried chewing tobacco at age 10 or younger.

#31. During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?

Results: 89.3% answered zero days to smoking some type of cigar: 92.7% of girls, and 85.6% of boys. 6% answered 1-2 days, and less than 5% answered 3 or more days.

Factoid: The average age of first tobacco use [nationally] is 12.2 years for children aged 12 to 17.

- 1 out of 2 eighth-graders has tried cigarettes.
- 1 out of 12 eighth-graders smokes cigarettes daily.

www.health.org/pepscommunity/facts.htm

ALCOHOL AND ILLICIT DRUG USE

Alcohol and illicit drug use are associated with child and spousal abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; motor vehicle crashes; escalation of health care costs; low worker productivity; and homelessness. Alcohol and illicit drug use also can result in substantial disruptions in family, work, and personal life.

Alcohol abuse alone is associated with motor vehicle crashes, homicides, suicides, and drowning-leading causes of death among youth. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation.

Adolescents. Although the trend from 1994 to 1998 has shown some fluctuations, about 77 percent of adolescents aged 12 to 17 years report being both alcohol free and drug free in the past month. In the same year, 6 percent of adults aged 18 years and older reported using illicit drugs in the past month.

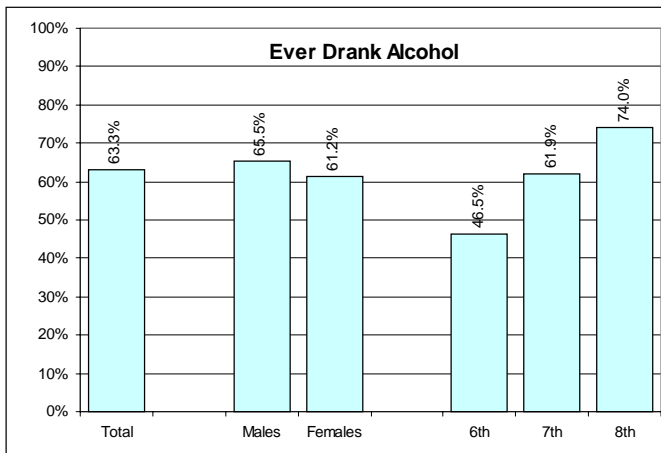
Alcohol is the drug most frequently used by adolescents aged 12 to 17 years. In 1998, 19 percent of adolescents aged 12 to 17 years reported drinking alcohol in the past month. Alcohol use in the past month for this age group has remained at about 20 percent since 1992. Eight percent of this age group reported binge drinking, and 3 percent were heavy drinkers (five or more drinks on the same occasion on each of 5 or more days in the past 30 days).

Data from 1998 show that 10 percent of adolescents aged 12 to 17 years reported using illicit drugs in the past 30 days. This rate remains well below the all-time high of 16 percent in 1979. Current illicit drug use had nearly doubled for those aged 12 to 13 years between 1996 and 1997 but then decreased between 1997 and 1998. Youth are experimenting with a variety of illicit drugs, including marijuana, cocaine, crack, heroin, acid, inhalants, and methamphetamines, as well as misuse of prescription drugs and other "street" drugs. The younger a person becomes a habitual user of illicit drugs, the stronger the addiction becomes and the more difficult it is to stop use.

Adults. Binge drinking has remained at the same approximate level of 17 percent for all adults since 1988, with the highest current rate of 32 percent among adults aged 18 to 25 years. Illicit drug use has been near the present rate of 6 percent since 1980. Men continue to have higher rates of illicit drug use than women have, and rates of illicit drug use in urban areas are higher than in rural areas.

U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000. Online at <http://www.health.gov/healthypeople>

Question rationale: Alcohol is a major contributing factor in approximately half of all homicides, suicides, and motor vehicle crashes, which are the leading causes of death and disability among young people.²⁸ Heavy drinking among youth has been linked to multiple sexual partners, use of marijuana, and poor academic performance.²⁹

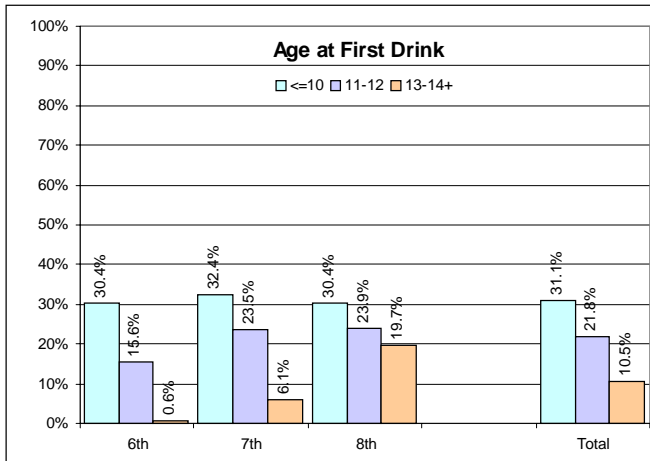


#32. Have you ever had a drink of alcohol, other than a few sips?

Results: There is little difference between boys and girls. 61.2% of girls and 65.5% of boys answered yes to ever having a drink. The increase in percentages with grade is notable, from 46.5% in 6th to 74% in 8th.

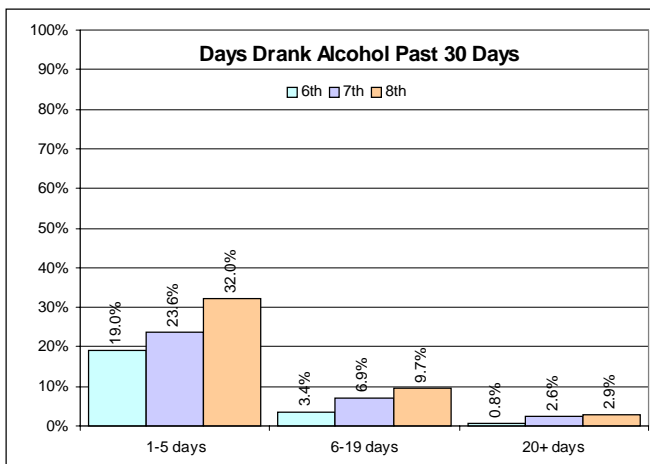
#33. How old were you when you had your first drink of alcohol other than a few sips?

Results: 31% of all respondents reported having their first drink of alcohol at age 10 or younger: 36.5% of boys and 26.2% of girls. 23.7% of 7th and 8th graders started between 11 and 12 years old.



#34. During the past 30 days, on how many days did you have at least one drink of alcohol?

Results: There is minimal difference between boys and girls: 64.5% of all respondents answered zero days having one drink of alcohol. The percentage that answered zero decreases with grade: 76.8% in 6th, 66.9% in 7th, and 55.3% in 8th. The percentage of some frequency of usage increases with grade.



Factoid: From 1989-1997 the rate of initiation of alcohol use among the 12-17 age group increased from 117.6 to 216.8 per 1,000 potential new users.
www.samhsa.gov/statistics/statistics.html

#35. How wrong would most adults in your community think it was for kids your age to drink alcohol?

#36. How wrong do your parents feel it would be for you to drink alcohol regularly?

#37. How wrong do you think it is for someone your age to drink alcohol regularly?

Results: 82.9% think that adults in the community would think it is wrong to very wrong for kids this age to drink alcohol; 89.2% think that their parents would think it is wrong for kids this age to drink alcohol; but 70.7% think it is wrong for kids their own age to drink alcohol.

Factoid: Junior and senior high school students drink 35 percent of all wine coolers sold in the United States and 1.1 billion cans of beer each year.
<http://oig.hhs.gov/oeci/summaries/b352.pdf>

#38. If you wanted to get some beer, wine, or hard liquor, how easy would it be for you to get some?

Factoid: More than 3 million students drink alone, more than 4 million drink when they are upset, and less than 3 million drink because they are bored.
www.samhsa.gov/statistics/statistics.html

Results: 49.1% say that it would be very to sort of easy to get alcohol; 31.2% say that it would be very hard.

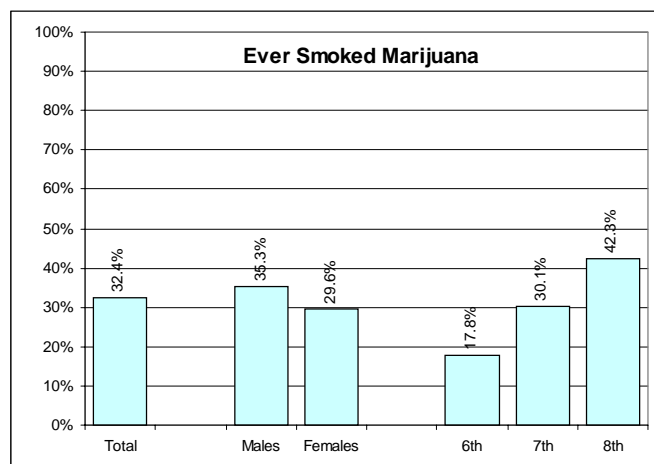
#39. How much do you think people risk harming themselves physically or in other ways if they take one or two drinks of an alcoholic beverage (beer, wine, or liquor) nearly every day?

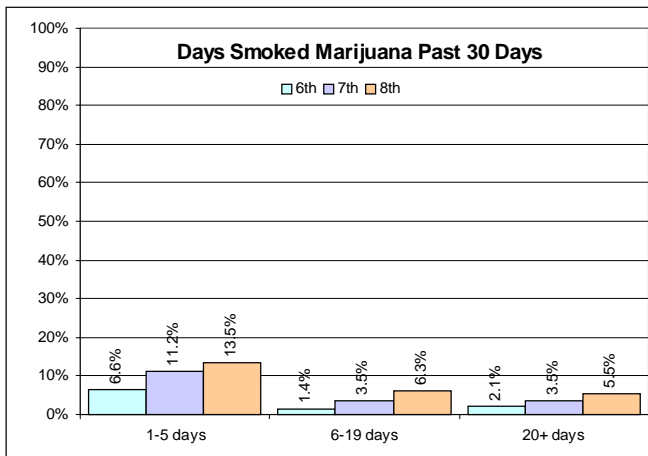
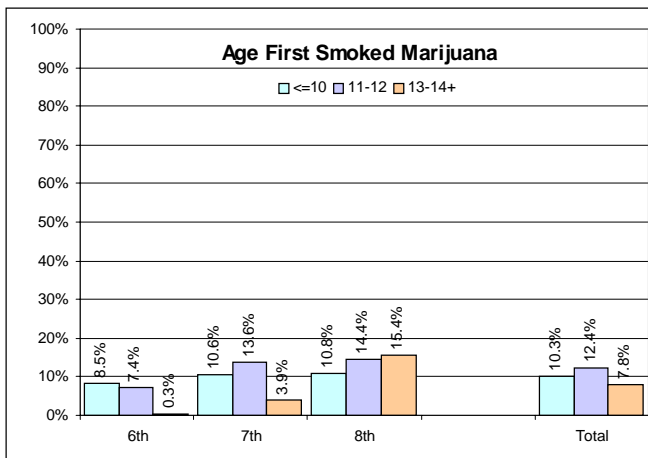
Results: 29.6% answered that there is no to slight risk in taking one or two alcoholic drinks nearly every day; 40% answered there is great risk. More 8th graders than 6th graders think the risk is slight to moderate (54.6%, 42.7%).

Question rationale: In addition to morbidity and mortality due to injury, drug abuse is related to suicide, early unwanted pregnancy, school failure, delinquency, and transmissions of sexually transmitted diseases (STD), including human immunodeficiency virus (HIV) infection.^{30,31} Despite improvements in recent years, drug use is greater among high school students and other young adults in the U.S. than has been documented in any other industrialized nation in the world.³²

#40. Have you ever used marijuana?

Results: 32.4% reported ever using marijuana: 35.3% of boys, 29.6% of girls. The percentage answering yes to this question increases from 17.8% in 6th grade to 42.3% in 8th grade.





#41. How old were you when you tried marijuana for the first time?

Results: 69.4% say they have never tried marijuana: 72% of girls and 66.6% of boys. 10.3% of all respondents tried marijuana at age 10 or younger: 8.1% of girls and 12.6% of boys.

#42. During the past 30 days, on how many days did you use marijuana at least once?

Results: With minimal difference between boys and girls, 80.7% of all respondents said they had not used marijuana in the 30 days prior to the survey: 90% of 6th graders, 81.8% of 7th graders, and 74.6% of 8th graders.

#43. How wrong would most adults in your community think it was for kids your age to use marijuana?

#44. How wrong do your parents feel it would be for you to smoke marijuana?

#45. How wrong do you think it is for someone your age to smoke marijuana?

Results: 91.6% (minimal difference between boys and girls) think that adults in the community would think it is wrong to

very wrong for kids this age to use marijuana; and 95.1% think that their parents would think it is wrong for kids this age to smoke marijuana; but 79.3% think it is wrong for kids their own age to smoke marijuana.

#46. How much do you think people risk harming themselves (physically or in other ways) if they try marijuana once or twice?

#48. How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly?

Results: 34.4% of all respondents answered there is no to slight risk smoking marijuana regularly; 45% answered there is great risk. More 8th graders than 6th graders (27.9% in 6th to 40.2% in 8th) think there is no to slight risk, and fewer 8th graders than 6th (38.8% in 8th to 52.7% in 6th) think there is great risk.

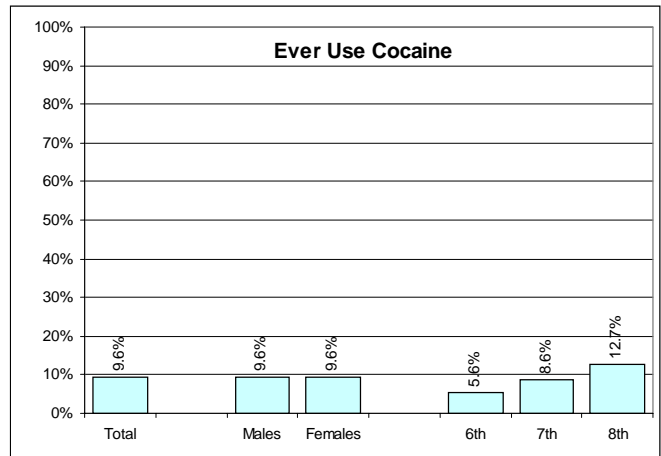
#47. If you wanted to get some marijuana, how easy would it be for you to get some?

Results: 39.8% of all respondents said that it would be very to sort of easy to get marijuana; 45.7% thought it would be very hard.

Factoid: Among 12-17 year olds, there was an 11 percent decrease in emergency room visits for drug-related reasons from 1998 to 1999.
<http://www.hhs.gov/news/press/2000pres/00fsmf.html>

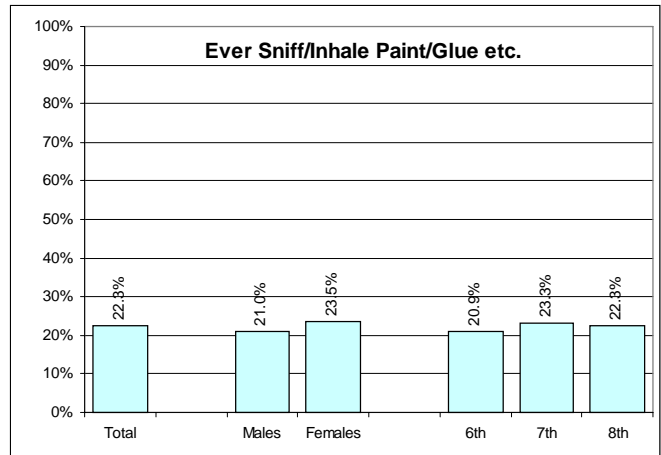
#49. Have you ever used any form of cocaine, including powder, crack, or freebase?

Results: 9.6% of all respondents answered yes, with no difference between boys and girls. By grade, 5.6% of 6th graders; 8.6% of 7th graders, and 12.7% of 8th graders had tried cocaine.



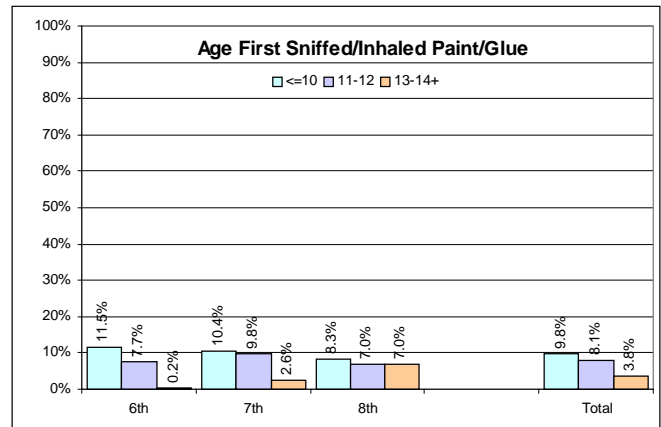
#50. Have you ever sniffed glue, or breathed the contents of spray cans, or inhaled any paints or sprays to get high?

Results: 22.3% of respondents answered yes, with very little difference between boys and girls, and very little difference by grade.



#51. How old were you when you sniffed glue, or breathed the contents of spray cans, or inhaled any paints or sprays to get high for the first time?

Results: 9.8% of all respondents said they sniffed or inhaled at age 10 or younger: 11.1% of boys and 8.6% of girls. There is a decrease by grade of those who started at age 10 or younger; 8.3% of current 8th graders, 10.4% of current 7th graders, and 11.5% of current 6th graders started at age 10 or younger. If this trend were to hold, this might be a cohort effect: each succeeding age group is starting younger.



#52. During the past 30 days, on how many days did you sniff glue, breathe the contents of spray cans, or inhale any paints or sprays at least once?

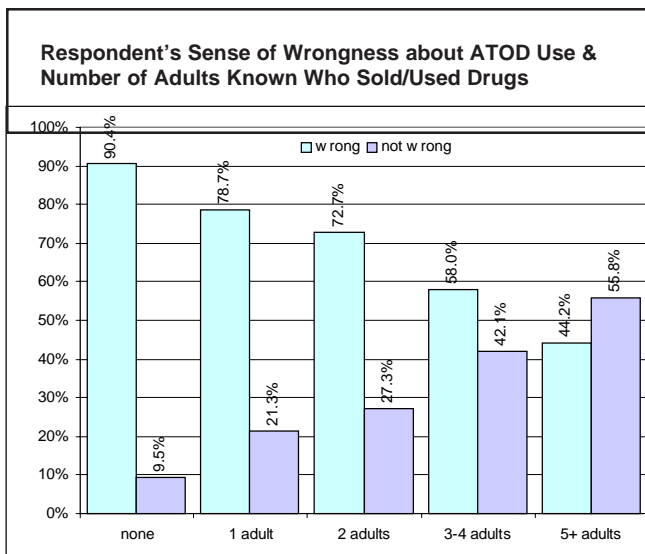
Results: 88.8% of all respondents answered they did not sniff or inhale in the 30 days prior to the survey. 8% sniffed or inhaled 1-5 days out of the previous 30. Less than 2% sniffed or inhaled on 6-19 days, and about 1% sniffed or inhaled on 20 or more days out of the previous 30.

#53. Have you ever used steroids?

Results: 6.1% of respondents have used steroids: 8.2% of boys, 4.2% of girls, with minimal difference between grades.

#54. Have you ever used a needle to inject any illegal drug into your body?

Results: 5.5% of respondents have ever used a needle: 6.7% of boys, 4.4% of girls, with no difference between grades.



#55. About how many adults have you known personally who in the past year have used marijuana, crack, or other drugs?

Results: More boys (46.8%) than girls (42.5%) said they haven't known any adults who have used drugs. 35.3% of girls to 30.5% of boys said they've known 3 or more adults who have used drugs in the past year. The number who have known 3 or more adults that used drugs increases with grade: 23.8% in 6th to 39.6% in 8th grade.

#56. About how many adults have you known personally who in the past year have sold or dealt drugs?

Results: About 59% of both boys and girls said they haven't known any adults who have sold or dealt drugs. About 20% of all respondents said they've known 3 or more adults who have sold or dealt drugs in the past year. The number who have known 3 or more adults that sold or dealt drugs increases with grade: 11.5% in 6th to 25.9% in 8th grade.

There is a strong association between how many people respondents have known that sold or used drugs (Qs. 55 and 56 combined) and respondents' personal sense of wrongness of ATOD use (Qs. 26, 37, 45, and 58 combined): as the number of adults known who have used or sold drugs increases, the perception of wrongness of drug use decreases.

#57. If you wanted to get some cocaine, LSD, or amphetamines, how easy would it be for you to get some?

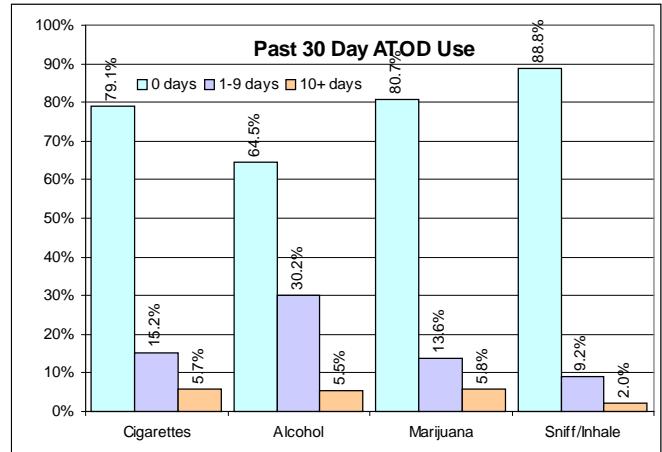
Results: There is not much difference between boys and girls. 20% of both said it would very to sort of easy to get cocaine, LSD, or amphetamines. The percentage increases with grade: 11.6% of 6th graders, 17.1% of 7th graders, and 29% of 8th graders answered very to sort of easy.

#58. How wrong do you think it is for someone your age to use LSD, cocaine, amphetamines, or another illegal drug?

Results: Only 7.2% of all respondents, no difference between boys and girls, answered that it would be a little bit to not wrong at all to use illegal drugs. There is an increase with grade: 4.2% of 6th graders answered a little bit to not wrong at all compared to 9.4% of 8th graders.

Comparing 30-day use among substances

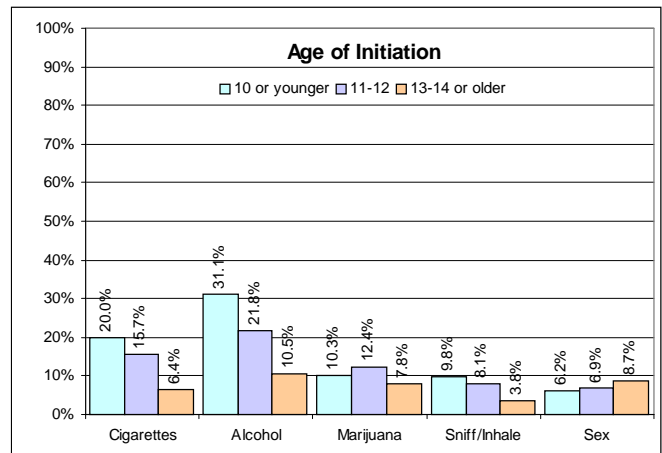
For past 30-day use of cigarettes, alcohol, marijuana, and sniffing/inhaling paint or glue, more respondents use alcohol than use the other substances. Cigarette smoking and marijuana use are about the same. The percentage using any of these substances for 10 or more days out of the past 30 is small.



Factoid: People who begin smoking before age 13 are significantly more likely than nonsmokers and those who begin smoking later to have problems with alcohol and other drugs.
<http://www.ncadd.org/facts/youthalc.html>

Age of first use

More respondents reported starting cigarettes and alcohol at age 10 or younger than the other substances (marijuana or sniffing/inhaling) or than having sexual intercourse. More respondents waited until age 13 or older to have sex for the first time than tried ATOD use for the first time.



Factoid: Among youth age 12-17, the incidence rate [of use of psychotherapeutics and non-prescription pain relieving drugs] has increased from 6.3 per 1,000 potential new users in 1990 to 32.4 in 1998.
www.samhsa.gov/statistics/statistics.html

SEXUAL BEHAVIOR

Unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus that causes AIDS, can result from unprotected sexual behaviors. Abstinence is the only method of complete protection. Condoms, if used correctly and consistently, can help prevent both unintended pregnancy and STDs.

In 1999, 85 percent of adolescents abstained from sexual intercourse or used condoms if they were sexually active. In 1995, 23 percent of sexually active women reported that their partners used condoms.

In the past 6 years there has been both an increase in abstinence among all youth and an increase in condom use among those young people who are sexually active. Research has shown clearly that the most effective school-based programs are comprehensive ones that include a focus on abstinence and condom use. Condom use in sexually active adults has remained steady at about 25 percent.

Half of all pregnancies in the United States are unintended; that is, at the time of conception the pregnancy was not planned or not wanted. Unintended pregnancy rates in the United States have been declining. The rates remain highest among teenagers, women aged 40 years or older, and low-income African American women. Approximately 1 million teenage girls each year in the United States have unintended pregnancies. Nearly half of all unintended pregnancies end in abortion.

Sexually transmitted diseases are common in the United States, with an estimated 15 million new cases of STDs reported each year. Almost 4 million of the new cases of STDs each year occur in adolescents. Women generally suffer more serious STD complications than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the human papilloma virus. African Americans and Hispanics have higher rates of STDs than whites.

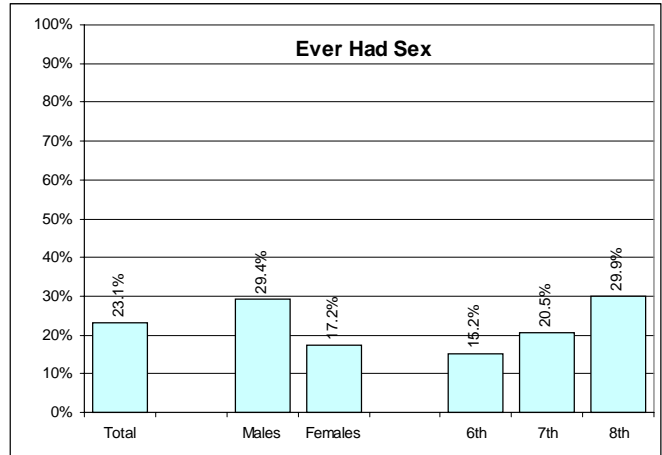
Nearly 700,000 cases of AIDS have been reported in the United States since the HIV/AIDS epidemic began in the 1980s. The latest estimates indicate that 800,000 to 900,000 people in the United States currently are infected with HIV. About one-half of all new HIV infections in the United States are among people under age 25 years, and the majority are infected through sexual behavior. Compelling worldwide evidence indicates that the presence of other STDs increases the likelihood of both transmitting and acquiring HIV infection.

U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000. Online at <http://www.health.gov/healthypeople>

Question rationale: Early sexual activity is associated with unwanted pregnancy and sexually transmitted diseases (STD), including HIV infection, and negative effects on social and psychological development.³³ Number of sexual partners and age at first intercourse are associated with increased risk for STD. Alcohol and other drug use may serve as predisposing factors for initiation of sexual activity and unprotected sexual intercourse.³⁴ AIDS is the 6th leading cause of death for youth aged 15-24.⁶ Use of latex condoms by males, when used consistently and correctly, are highly effective at reducing the risk of HIV infection and other sexually transmitted diseases (STDs).³⁵ In 1994, 86% of middle/junior and senior high schools taught HIV prevention education in a required course.³⁶

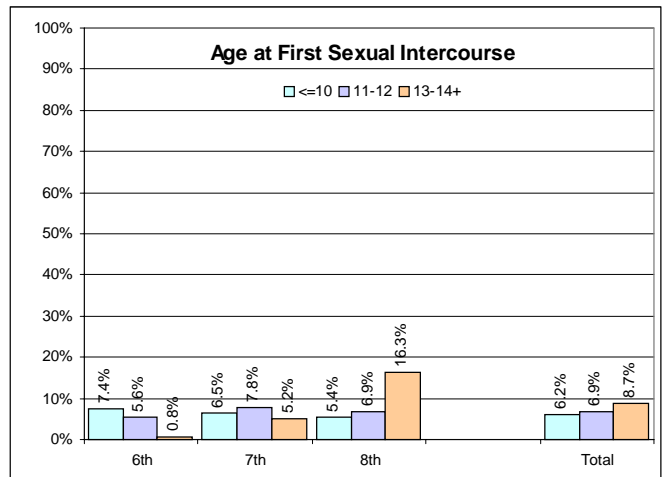
#59. Have you ever had sexual intercourse?

Results: 29.4% of boys and 17.2% of girls answered yes to having had sexual intercourse. There is an increase with grade: 15.2% of 6th graders to 29.9% of 8th graders.



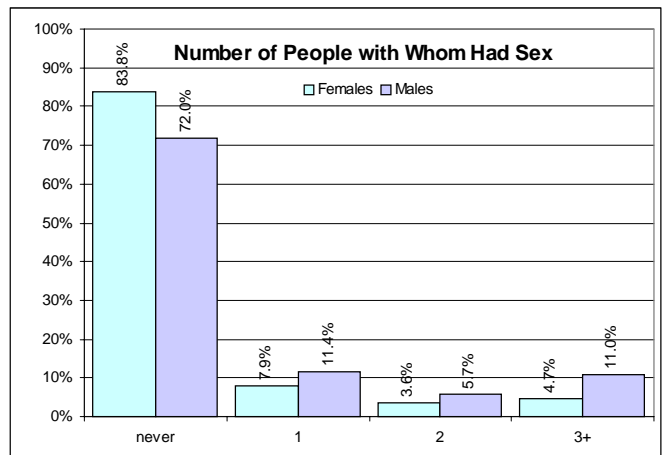
#60. How old were you when you had sexual intercourse for the first time?

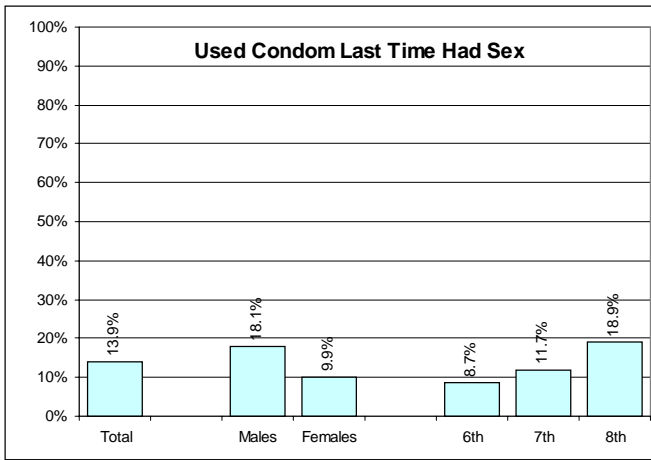
Results: 9.1% of boys and 3.7% of girls reported having their first sexual intercourse at age 10 or younger. A smaller percentage of current 8th graders than current 6th graders first had sex at age 10 or younger.



#61. With how many people have you ever had sexual intercourse?

7% of 6th graders and 12.6% of 8th graders said they'd only had sex with one person. 5% of 6th graders and 10% of 8th graders said they'd had sex with 3 or more people.



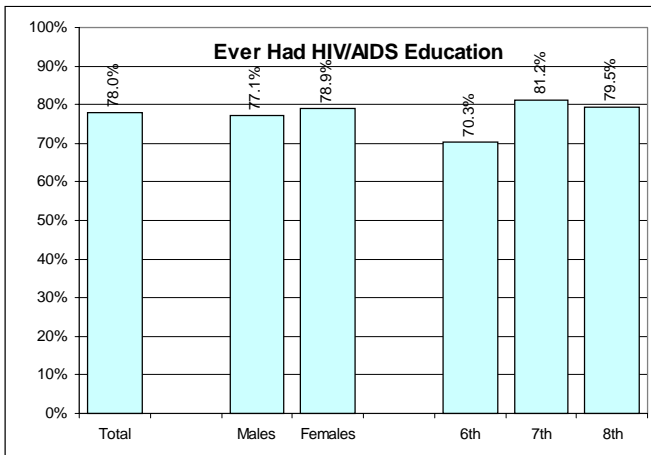


#62. The last time you had sexual intercourse, did you or your partner use a condom?

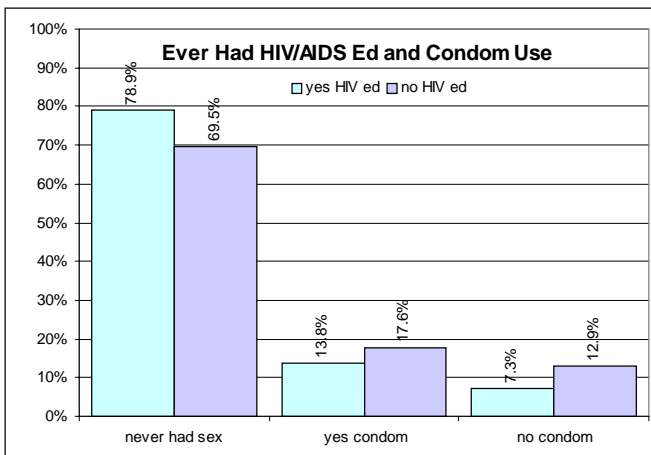
Results: 18.1% of boys and 9.9% of girls reported condom use the last time they had sexual intercourse.

#75. Have you ever been taught about AIDS or HIV infection in school?

Results: 78% of all respondents answered yes; 9.6% aren't sure. 70.3% of 6th graders, 81.2% of 7th graders, and 79.5% of 8th graders answered yes.



There is an association between having had HIV/AIDS Education in school, sexual activity, and condom use. Of those respondents who had HIV/AIDS education, more had never had sex than among those that had not had HIV/AIDS education. Of those respondents that had HIV/AIDS education and were sexually active, more used condoms than didn't. This is also reflected in the frequencies of those that had not had HIV/AIDS education and were sexually active: more used condoms than didn't. This could possibly be attributed to those who have had HIV/AIDS education disseminating the message about condom use to their peers.



Factoid: Often teens report that their first sexual experience was one they did not plan or foresee, but rather that "just happened."
Dangerous Liaisons: Substance Abuse and Sex, Dec 99. On-line at www.health.org/research/studies.htm

NUTRITION AND PHYSICAL ACTIVITY

In 1999, 65 percent of adolescents engaged in the recommended amount of physical activity. In 1997, only 15 percent of adults performed the recommended amount of physical activity, and 40 percent of adults engaged in no leisure-time physical activity.

Regular physical activity is associated with lower death rates for adults of any age, even when only moderate levels of physical activity are performed. Regular physical activity decreases the risk of death from heart disease, lowers the risk of developing diabetes, and is associated with a decreased risk of colon cancer. Regular physical activity also increases muscle and bone strength, increases lean muscle and helps decrease body fat, aids in weight control and is a key part of any weight loss effort, enhances psychological well-being and may even reduce the risk of developing depression, and appears to reduce symptoms of depression and anxiety and to improve mood. In addition, children and adolescents need weight-bearing exercise for normal skeletal development, and young adults need such exercise to achieve and maintain peak bone mass. Regular physical activity also increases the ability of people with certain chronic, disabling conditions to perform activities of daily living.

- ◆ Women generally are less active than men at all ages.
- ◆ People with lower incomes and less education are typically not as physically active as those with higher incomes and education.
- ◆ African Americans and Hispanics are generally less physically active than whites.
- ◆ Adults in northeastern and southern States tend to be less active than adults in North-Central and Western States.

The major barriers most people face when trying to increase physical activity are lack of time, lack of access to convenient facilities, and lack of safe environments in which to be active.

Overweight and obesity are major contributors to many preventable causes of death. On average, higher body weights are associated with higher death rates. The number of overweight children, adolescents, and adults has risen over the past four decades. During 1988-94, 11 percent of children and adolescents aged 6 to 19 years were overweight or obese. During the same years, 23 percent of adults aged 20 years and older were considered obese.

Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem.

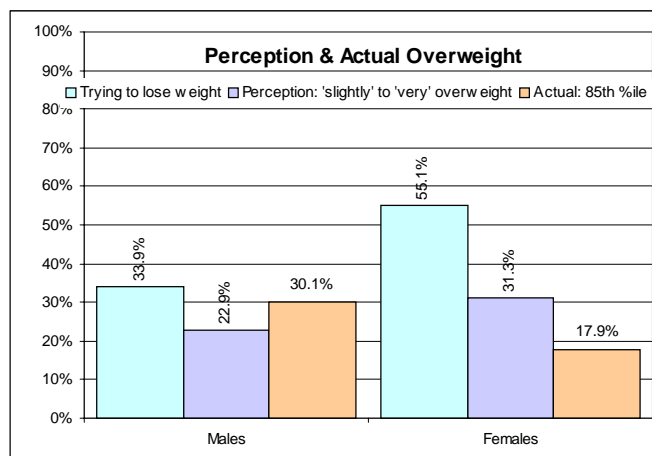
The proportion of adolescents from poor households who are overweight or obese is twice that of adolescents from middle- and high-income households.

U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000. Online at <http://www.health.gov/healthypeople>

Question rationale: Data on self-reported height and weight can be used to calculate body mass index and provide a reasonable proxy measure of whether students are overweight. Although overweight prevalence estimates derived from self-reported data are likely to be low,^{40,41} they can be useful in tracking trends over time. Prevalence trends from national surveys of adults using self-reported height and weight have been consistent with trend data from national surveys using measured heights and weights.⁴² The prevalence of overweight among adolescents more than doubled from 5% in the late 1970s to 11% between 1988 and 1994.⁴³ Overweight or obesity acquired during childhood or adolescence may persist into adulthood and increase the risk later in life for coronary heart disease, gallbladder disease, some types of cancer, and osteoarthritis of the weight-bearing joints.⁴⁴ In adolescence, obesity is associated with hyperlipidemia, hypertension, abnormal glucose tolerance, and adverse psychological and social consequences.⁴⁵ Studies have shown high rates of

Factoid: Overweight and obesity affect a large proportion of the U.S. population-55 percent of adults. Between 1976 and 1994, the number of cases of obesity alone increased more than 50 percent-from 14.5 percent of the adult population to 22.5 percent. Overweight and obesity acquired during childhood or adolescence may persist into adulthood and increase the risk for some chronic diseases later in life.

http://www.health.gov/healthypeople/Document/HTML/Volume2/19Nutrition.htm#_Toc490383123



body dissatisfaction and dieting among adolescent females, with many engaging in unhealthy weight control behaviors, such as fasting and self-induced vomiting.⁴⁶⁻⁴⁹

#63. How do you describe your weight?

#64. Which of the following are you trying to do about your weight?

Results: 6.2% of girls and 3% of boys describe themselves as very overweight. However, a larger percentage of males, 11%, are actually overweight (in the 95th percentile of overweight BMI. See Appendix for full explanation.) than perceive themselves as such compared to 5.2% of girls. A larger percentage of girls perceive themselves as slightly to very overweight, 31.3%, than actually are, 17.9% (in the 85th percentile, at risk for obesity). However, a much larger percentage of girls are trying to lose weight (55.1%) than answered that they were slightly to very overweight (31.3%).

#65. Have you ever exercised to lose weight or to keep from gaining weight?

Results: 73.6% of girls and 55% of boys reported having exercised to lose or keep from gaining weight. There is no difference by grade.

#66. Have you ever eaten less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight?

Results: 53.2% of girls and 30.6% of boys have eaten less to lose or keep from gaining weight. There is minimal difference by grade.

#67. Have you ever gone without eating for 24 hours or more (also called fasting) to lose weight or to keep from gaining weight?

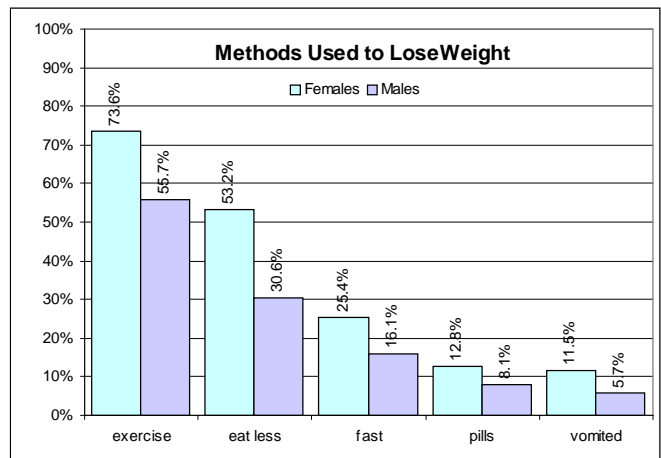
Results: 25.4% of girls and 16.1% of boys have fasted to lose or keep from gaining weight. There is no difference by grade.

#68. Have you ever taken any diet pills, powders, or liquids without a doctor's advice to lose weight or to keep from gaining weight?

Results: 12.8% of girls and 8.1% of boys have taken diet pills to lose or keep from gaining weight. There is an increase by grade: 8.4% of 6th graders to 12.9% of 8th graders have taken diet pills, powders, or liquids.

#69. Have you ever vomited or taken laxatives to lose weight or to keep from gaining weight?

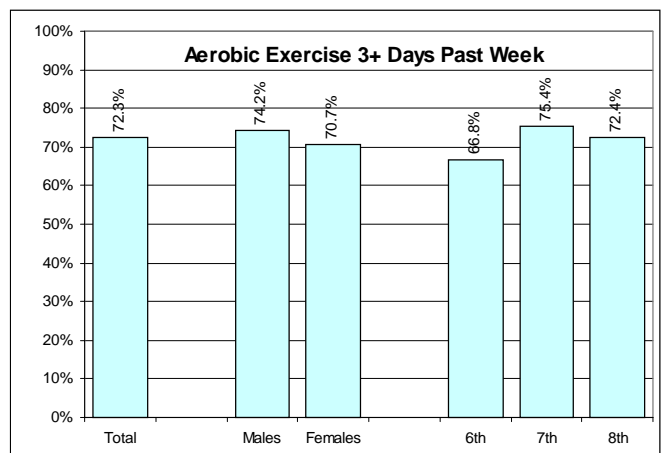
Results: 11.5% of girls and 5.7% of boys have vomited or taken laxatives to lose or keep from gaining weight. There is an increase with grade: 7.7% of 6th graders to 10.1% of 8th graders have vomited or taken laxatives.

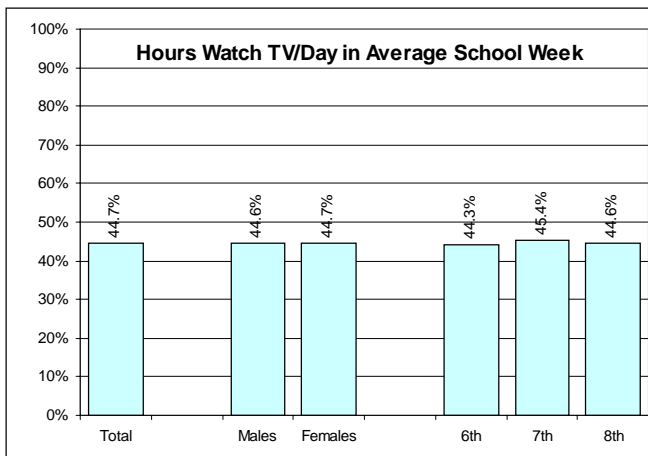


Question rationale: Participation in regular physical activity helps build and maintain healthy bones and muscles, control weight, build lean muscle, and reduce fat; reduces feelings of depression and anxiety; and promotes psychological well-being.⁵⁶ Major decreases in vigorous physical activity occur during grades 9-12, particularly for girls; by 11th grade, more than half of female students are not participating regularly in vigorous physical activity.⁵⁶ School physical education classes can increase adolescent participation in moderate to vigorous physical activity^{57,58} and help adolescents develop the knowledge, attitudes, and skills they need to engage in lifelong physical activity.⁵⁹ Television viewing is the principal sedentary leisure time behavior in the U.S. and studies have shown that television viewing in young people is related to obesity⁶⁰ and violent or aggressive behavior.^{61,62}

#70. On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities?

Results: 72.3% of all respondents answered yes to strenuous exercise in the 7 days prior to the survey: 74.2% of boys and 70.5% of girls. There is no difference by grade.



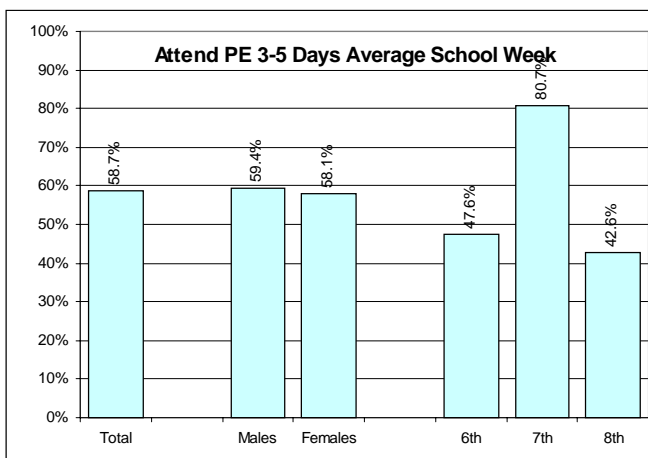


#71. On an average school day, how many hours do you watch TV?

Results: 44.6% of all respondents watch 3 or more hours of TV on an average school day. There is no difference by grade.

#72. In an average week when you are in school, on how many days do you go to physical education (PE) classes?

Results: 58.7% of all respondents go to PE 3 or more days in an average school week. There is a definite change with grade: 47.6% of 6th graders, 80.7% of 7th graders, and 42.6% of 8th graders go to PE classes 3 or more days in an average school week.



#73. Do you play on any sports teams?

Results: 60.4% of all respondents, 57.5% of girls and 63.5% of boys, answered yes to playing on a sports team. There is no difference by grade.

#74. Have you ever been injured while exercising, playing sports, or being physically active and had to be treated by a doctor or nurse?

51.9% of all respondents were injured sufficiently to require some kind of medical treatment: 54.9% of boys and 49.1% of girls. The difference by grade is minimal.

Factoid: Only 19 percent of all high school students are physically active for 20 minutes or more, five days a week, in physical education classes.
<http://www.cdc.gov/nccdphp/sgr/adoles.htm>

APPENDICES

Sampling Design
Race/Ethnicity Categories
References for Question Rationales
Height, Weight, and BMI, How to Calculate
NM 2000 Middle School Youth Risk Behavior Survey

SAMPLING DESIGN

The district samples were drawn according to the following design:

A formula was determined (see L. Kish, Survey Sampling, pp. 41-43) for the purpose of drawing an unbiased and efficient sample within each school district requesting data. To estimate the necessary sample size for each school district, using the finite population correction (per Kish et. al.), we assumed that:

- the variance of a typical variable of interest to the district is approximated by a dichotomous variable with proportion mean=.5, and
- the goal is for sample means to estimate population means within + or - .05 with 95% confidence.

Solving the appropriate equation for n for each district provided the minimum sample size necessary to meet these conditions.

Once the equation was solved and the final sample size was determined, the sampling interval within classes was determined using the sample size as a proportion of the total 6-8th grade enrollment (except K-6 schools) of the selected district. If there was more than one school participating from a district, the class lists from all schools were combined, sorted according to size, descending, and the interval applied.

Classes were selected from 2nd period class lists provided by the schools. 2nd period classes were used instead of English classes because, given that the necessary criterion was that EVERY student must have an EQUAL chance to be selected for the sample but only one chance, 1) some students would not necessarily be in an English class, or 2) some might be in two English classes. Every student HAD to be somewhere in 2nd period, but not every student would be in an English class.

The sample size was increased by 15% to allow for absences and parental refusals. Also, in some smaller districts where the desired sample nearly equalled the total enrollment, enough surveys were provided for a census in that district. The number of surveys sent to a school was additionally increased according to the enrollment in the classrooms selected for the sample. The sampling formula provides an interval for selecting classrooms. If the total enrollment in the selected classrooms added up to more than the desired sample size, students were not excluded; excepting parental refusals, all students in a classroom participated.

The school district samples provide unbiased estimates for each school district, but because participating districts were not selected randomly, aggregating the responses for all districts does not provide good estimates at the state level.

RACE/ETHNICITY

Respondents were categorized by race/ethnicity following the Center for Disease Control and Prevention's guidelines. This is the CDC's protocol for tabulating ethnicity.

1999-2000 YRBS RACE/ETHNICITY TABULATIONS

The 1999 and 2000 YRBS questionnaires contain the following "Choose all that apply" race/ethnicity question.

4. How do you describe yourself? (Select one or more responses.)

- A. American Indian or Alaska Native
- B. Asian
- C. Black or African American
- D. Hispanic or Latino
- E. Native Hawaiian or Other Pacific Islander
- F. White

If respondents select only one response, then race/ethnicity is set to "1" to "6" to match that response. If they select more than one response and include Hispanic, then race/ethnicity is set to "7" indicating "Multiple – Hispanic". If they select more than one response and do not include Hispanic, then race/ethnicity is set to "8" indicating "Multiple – Non-Hispanic". If they do not select anything, then race/ethnicity is set to missing. The original selected responses and the single, calculated race/ethnicity variable are both stored on the data sent to the sites.

The number of columns in tables will vary from site to site depending on the breakdown at each site. Race/ethnicity is tabulated according to the following conditions: "Hispanic" and "Multiple – Hispanic" are collapsed into "Hispanic". Any race with more than 100 respondents is reported separately as its own column. If there are two or more races that have fewer than 100 respondents, they are collapsed into "All Other Races". "Multiple – Non-Hispanic" has its own column regardless of the number of respondents. Tables will have a maximum of seven columns. The following key will be included at the front of the report section in sites' materials.

| <u>Report Heading</u> | <u>Indicates</u> |
|-----------------------------------|---|
| American Indian or Alaska Native: | A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. |
| Asian: | A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. |
| Black or African American: | A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." |

| | |
|--|---|
| Hispanic or Latino: | A person of Cuban, Mexican, Puerto Rican, South or Central-American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino." |
| Multiple Hispanic: | This category includes respondents who selected multiple responses and included "Hispanic or Latino." |
| Native Hawaiian or Hawaii, Other Pacific Islander: | A person having origins in any of the original peoples of Guam, Samoa, or other Pacific Islands. |
| White: | A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. |
| All Other Races | The aggregate count of the above six races when there are less than 100 respondents for a given race. |
| Multiple Other | Respondents who selected multiple responses but did not include "Hispanic or Latino." |

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Youth Risk Behavior Survey *Height, Weight and BMI*

Basic Edits: Height is scanned as a three-column character variable from columns 45-47 of the ASCII file. It is not compressed or justified by the scanning program. The system reads it into `q5_orig`. The first column ranges from “3” to “7” and indicates whole feet; the second and third columns range from “00” to “11” and indicate inches. If either feet or inches isn’t filled in or is unreadable, then both are set to missing and `Q5` is set to missing. If it was filled in correctly, it is converted to meters by the formula

$$Q5 = (Q5_origft \times 12 + Q5_origin) \times 0.0254 \frac{m}{in}$$

`Q5` is stored as a numeric variable formatted as 8.2. `Q5_orig` is stored on CDC’s copy of the data but is not included on the data file that is sent to the site.

Weight is scanned as a three-column character variable from 48-50 of the ASCII file. It is not compressed or justified by the scanning program. The processing system reads it into `q6_orig`. The first column indicate 100s of pounds and ranges from “0” to “3”; the second column indicates 10s of pounds and ranges from “0” to “9”; the third column indicates single pounds and ranges from “0” to “9”. If any column is left blank or is unreadable, all columns are set to missing and `Q6` is set to missing. If it was filled in correctly, it is converted to kilograms by the formula

$$Q6 = q6_orig \times 0.4536 \frac{kg}{lb}$$

`Q6` is stored as a numeric variable formatted as 8.2. `Q6_orig` is stored on CDC’s copy of the data but is not included on the data file that is sent to the site.

If `Q5` is missing, `Q6` is set to missing. If `Q6` is missing, `Q5` is set to missing.

If `Q5` and `Q6` are missing, BMI is set to missing. If `Q5` and `Q6` pass basic data edits, Body Mass Index (BMI) is calculated by the formula

$$BMI = \frac{kg}{m^2} = \frac{Q6}{Q5^2}$$

BMI is stored on CDC’s dataset as a numeric variable formatted as 8.2.

Logical Edits: When basic edits are complete, logical edits are applied to Q5, Q6, and BMI to make sure that the results are reasonable. Q5, Q6, and BMI are set to missing if age or sex is unknown. Q5, Q6, and BMI are set to missing when an observation lies outside the following limits. These limits were developed by the Division of Nutrition and Physical Activity.

| Age | Males | Females |
|-------|--|--|
| ≤10 | Weight: 13.61-90.72 kg Height: .94-1.68 m BMI: 11.5 –41 | Weight: 13.61-90.72 kg Height: .94-1.73 m BMI: 11-40 |
| 11-12 | Weight: 20.41-136.08 kg Height: 1.02-1.83 m BMI: 11.5-41 | Weight: 15.88-136.08 kg Height: 1.02-1.83 m BMI: 11-40 |
| 13-14 | Weight: 27.22-181.44 kg Height: 1.27-1.98 m BMI: 13-55 | Weight: 27.22-181.44 kg Height: 1.27-1.98 m BMI: 13-55 |
| ≥15 | Weight: 31.75-181.44 kg Height: 1.27-2.11 m BMI: 13-55 | Weight: 27.22-181.44 kg Height: 1.27-1.98 m BMI: 13-55 |

The loading report includes the number of questionnaires that did not pass basic edits and the number that did not pass logical edits.

Dichotomous variables for ‘risk of overweight’ and ‘overweight’ are calculated for questionnaires that pass all edits. The following table contains the data used for calculating these variables.

| Reference Data for Obesity | | | | |
|----------------------------|------------------|------------------|------------------|------------------|
| Age | Males | | Females | |
| | 85 th | 95 th | 85 th | 95 th |
| ≤9 | 18.85 | 21.47 | 19.19 | 21.78 |
| 10 | 19.96 | 22.60 | 20.19 | 23.20 |
| 11 | 20.35 | 23.73 | 21.18 | 24.59 |
| 12 | 21.12 | 24.89 | 22.17 | 25.95 |
| 13 | 21.93 | 25.93 | 23.08 | 27.07 |
| 14 | 22.77 | 26.93 | 23.88 | 27.97 |
| 15 | 23.63 | 27.76 | 24.29 | 28.51 |
| 16 | 24.45 | 28.53 | 24.74 | 29.10 |
| 17 | 25.28 | 29.32 | 25.23 | 29.72 |
| ≥18 | 25.92 | 30.02 | 25.56 | 30.22 |

The source for the reference data is the National Health and Nutrition Examination Survey I.