

Acknowledgements

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- ODH Bureau of Community Health Services and Systems Development and Bureau of Health Services Information and Operational Support.

The following national organizations endorsed the Youth Risk Behavior Survey:

American Academy of Pediatrics

American Association for Health Education

American Association of School Administrators

American Cancer Society

American Medical Association

Association of State and Territorial Health Officials

Chronic Disease Directors

The Council of Chief State School Officers

Directors of Health Promotion and Education

The Institute for Youth Development

National Alliance of State and Territorial AIDS Directors

National Association of State Boards of Education

National Education Association Health Information Network

National PTA

National School Boards Association

Society of State Directors of Health, Physical Education and Recreation

What is the Youth Risk Behavior Survey?

The Youth Risk Behavior Survey (YRBS) was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to measure the prevalence of behaviors that contribute to the leading causes of death, disease and injury.

The YRBS is a multiple-choice survey conducted every two years and is designed to produce data representative of students in grades nine through 12. This information enables us to:

- Monitor trends in health and risk behavior.
- Compare Ohio students with a national sample of students.
- Plan, evaluate and improve community and school programs that prevent health problems and promote healthy behaviors.

Ohio first conducted the YRBS in 1993 with subsequent surveys in 1995 (unweighted data), 1997, 1999, 2003 and 2005. Through 1999, the survey was administered by the Ohio Department of Education. In 2001, Ohio did not participate in the YRBS and at that time a decision was made to move the administration of the survey to the Ohio Department of Health (ODH). As of 2003, staff in the bureaus of Community Health Services and Systems Development and Health Services Information and Operational Support in the Division of Family and Community Health Services at ODH collaborate to conduct the YRBS in Ohio.

Why Ohio Conducted the YRBS

The YRBS helps Ohioans identify high school students' current health and safety habits so improvements can be made where needed. Establishing healthy lifestyles for Ohio youth can lead to improved learning in the classroom and longer, more productive lives for Ohio's population.

People develop behavior patterns in their childhood and teen years which can eventually strengthen or threaten their quality and length of life. Currently, many adolescents in the United States use tobacco, alcohol, eat too much fat, consume too few fruits and vegetables and fail to exercise regularly. Students often can improve their health by making simple changes to what they do each day. Parents, school staff members and community groups can help students make the behavior changes necessary to improve their health by developing and supporting activities and environments that encourage healthy behaviors.

The 2005 YRBS provides Ohio with a reference point for evaluating future trends in health habits of youth. Survey results serve as a valuable tool, particularly for legislators, policymakers, school administrators and teachers as they make decisions about new disease prevention and health promotion policies, services, programs and educational activities. Specifically, YRBS findings form a valuable base upon which Ohio can strengthen its ability to:

- Establish disease prevention and health promotion policies.
- Plan and implement health-related programs and services.
- Secure funding for health-related programs.
- Allocate limited resources toward targeted needs and priorities.
- Conduct future research and note progress or deficiencies.
- Enact laws to prevent injuries and unnecessary deaths.

How the Survey was Conducted

During February – May 2005, students enrolled in high schools that had been selected by a scientific sampling process completed the Ohio YRBS. Their classes were randomly picked from master schedules submitted by school administrators. Research and sampling guidelines from the CDC were followed to make all selections scientifically valid. Following strict research procedures also ensured that:

- Selected schools, their administrators, parents and students were informed and voluntarily agreed to participate.
- Individual student identity remained anonymous in all reports.

Who Participated in the Survey?

The 99-item, multiple-choice YRBS was administered to 1,411 students in 49 Ohio public and non-public high schools in February – May 2005. This represented a school response rate of 73 percent and a student response rate of 86 percent. This was a response rate high enough to produce results which are representative of Ohio high school students as a group and allows an accurate comparison of Ohio results to YRBS findings for the nation.

How Results Can Be Interpreted

Background

Overall, Ohio's 2005 YRBS results are representative of what Ohio's ninth through 12th grade students as a group would have reported. This is because survey results were "weighted," which simply means each participant's answers represented that individual plus some others who were similar to that individual.

Ohio's 2005 YRBS is a "snapshot in time." It highlights the prevalence of risk behaviors reported by Ohio high school students during February – May 2005. These risk behaviors address seven priority areas identified by the CDC as the leading causes of morbidity and mortality among youth in the United States. These priority areas include intentional and unintentional injuries; tobacco use; alcohol and other drug use; sexual activity that leads to pregnancy and sexually transmitted infections including HIV; nutrition; physical activity; and positive youth behavior.

Answers in this survey were only as accurate as students' reporting. Each student interpreted the terms in each question according to his or her own definitions. For instance, is a pocket knife a "weapon"? What area does "on school property" include?

In some cases, the findings could under- or over-report behaviors. Some students chose not to answer certain questions, which means that all students surveyed were not represented in every response. However, enough students responded to survey questions to enable Ohio to compare its results to other states in the county.

Understanding 2005 Findings

The "2005 Findings" sections report the overall percentage of Ohio high school students engaging in a particular behavior. Information is reported by categories (total, gender, race and grade level) for each question. The 2005 findings are compared with 2003 and 1999 survey results where applicable.

A graphical representation of the data (bar graph) is provided for each question. Survey findings are also presented in words, using a bullet point format.

Data supplied from the YRBS provide Ohio with a means to compare the health of our youth with the rest of the nation. The national movement to improve the health of adolescents is based upon 21 critical objectives that focus on youth ages 10 – 24 years. These objectives have been selected from the more than 460 national objectives listed in Healthy People 2010 as critical health outcomes or contributing risk behaviors that can impact healthy youth development. The 21 critical objectives are listed as Healthy People Goals in the introduction to each survey topic area.

The answers reported on the YRBS are considered accurate and reliable because research protocols and scientific guidelines were followed. Survey findings could be identified as accurate, correct or "valid at the 95th percentile confidence level" because the percentage of participating students was sufficiently high. That is, if the survey were to be repeated 100 times, 95 times out of 100, similar results would be found. For each of the behavior-related questions (Q8-Q99), ranges for possible margins of error (confidence intervals) were calculated. For example, when comparing groups (e.g., males and females), if the confidence intervals for the groups do not overlap, then the results or the percentage differences are considered "significant." This means there is a statistical difference between the two groups being compared 95 percent of the time. If the word "significant" is not used in comparing the results of two groups, the difference between the percentages of the two groups may be due to chance rather than to a true difference.

For the purposes of this report, "estimate may not be reliable" refers to high sampling variability, where the ratio of the standard error to the estimate is greater than 30 percent. This is generally due to a small number of respondents. When this occurs, statistically meaningful comparisons cannot be made.

Students were grouped into three racial categories: White, Black and Other. Students classified as Other were those who designated themselves: Multi-racial; American Indian or Alaska Native; Asian; Hispanic or Latino; and Native Hawaiian or Other Pacific Islander. Assigning students to the Other race category in this manner helped increase the number of respondents in this category, allowing for comparisons between racial categories.

Percentages are reported in this survey for behavior-related questions 8 to 99 (i.e., Q8 to Q99) and are rounded according to CDC guidelines. Odd half numbers (e.g., 7.5 percent or 75.5 percent) were rounded up (e.g., to 8 percent or 76 percent), and even half numbers (e.g., 8.5 percent or 22.5 percent) were rounded down (e.g., to 8 percent or 22 percent).

For the 2005 YRBS, CDC conducted additional analysis of the data. Five findings were computed by analyzing two or three related questions to enhance the understanding of the issue. These are presented in a summary format and are not associated with a particular question.

Comparison between 1999, 2003 and 2005

For each question, the statements report all statistically significant changes in students' responses in 2005 compared to the 1999 and 2003 surveys.

Between 1999 and 2005, some questions were added, dropped or modified. Data are presented for all years that a question was asked.

Trends (1993 - 2005)

The section titled "Trends" reports changes in students' responses that took place between the 1993, 1997, 1999, 2003 and 2005 surveys. The YRBS was conducted in Ohio in 1995, but did not achieve a sufficient response threshold to receive weighted data. The survey was not conducted in 2001.

The statistically significant changes reported are for those differences between 1993 and 2005 only. Any significant changes that may have occurred between the other years are not reported in this report.

Interested individuals may request additional information. Researchers and professionals wanting to use Ohio's 2005 YRBS data may request detailed frequency tables from:

Ohio's Youth Risk Behavior Survey
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43215

Ohio YRBS reports can be accessed via the Internet at: <http://www.odh.ohio.gov>

How to Make Use of this Report

In this report, the questions are grouped into 11 sections: injury, violence, mental health, tobacco, alcohol, illegal drugs and prescription drug abuse, sexual behaviors, nutrition, physical activity, preventive health care and positive youth development. Each section has several questions included and each question is represented by a bar graph. The bar graphs contain data from 2003 and 2005 and significant differences between males and females, race or grade levels are described in the summary statements.

These data can be used in a variety of ways. Some of these include:

- Increasing awareness about the behaviors and risks experienced by high school students. This may help dispel myths and promote a more accurate view of the “average teenager.”
- Starting a discussion with teens about the health choices they are making and/or what is happening in their communities.
- Planning and evaluating programs to make sure they are truly meeting the needs of the community.

Injury

(Seat Belt Use, Drinking and Driving)

Motor vehicle crashes are the leading cause of death among 16- to 20-year-olds.¹ Lack of driving experience and a tendency to take risks are the two main reasons why this age group is more vulnerable. The Insurance Institute for Highway Safety states that teenagers are less likely to wear safety belts and belt use among male teens was significantly less than among females.

Drinking alcohol under the age of 21 is illegal. Driving while drunk is a serious offense with significant legal and financial consequences. Reducing drinking and driving or riding with someone who has been drinking alcohol can help reduce the number of motor vehicle crashes among teens.

- Lap/shoulder safety belts, when used, reduce the risk of fatal injury by 45 percent and the risk of moderate-to-critical injury by 50 percent.²
- Motor vehicle occupants 13 to 15 years old involved in fatal crashes have the lowest restraint use rate (27 percent); 21- to 24-year olds have the second-lowest restraint use rate (31 percent).²
- Motor vehicle crash injuries, approximately 31 percent of which involve alcohol, are the leading cause of death among youth 15 to 20 years of age in the United States.³

HP 2010 Objectives:

- | | |
|---------|--|
| 15-15: | Reduce deaths caused by motor vehicle crashes to no more than 9.2 per 100,000 people and no more than 0.8 per million vehicle miles traveled. |
| 15-19: | Increase use of safety belts to 92 percent. |
| 16-3: | Reduce deaths of adolescents and young adults to no more than 16.8 per 100,000 10-14-year-olds, 39.8 per 100,000 15-19-year-olds and 49.0 per 100,000 20-24-year-olds. |
| 26-01a: | Reduce deaths caused by alcohol-related motor vehicle crashes to no more than four per 100,000 people. |
| 26-01b: | Reduce injuries caused by alcohol-related motor vehicle crashes to no more than 65 per 100,000 people. |
| 26-06: | Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol to no more than 30 percent. |

Violence

(Weapons, Harassment, Physical Fighting)

Adolescents can experience violence along a continuum that may begin with verbal harassment and advance into physical acts of violence. Violence affects the quality of life of those who experience it and those who witness the acts. Violence towards female adolescents in the form of sexual coercion is also a growing concern.

Although school shootings have attracted much attention and public concern recently, the data support that the vast majority of America's schools are safe. Of all homicides and suicides among those 5-19 years of age, less than one percent occurs in or around school grounds or on the way to or from school.⁴

- Homicide is the second-leading cause of death among all youth aged 15-24.⁵
- More than 50 percent of all school-associated violent death events occurred during transition times during the school day – either at the beginning or end of the day or during lunch time.⁶
- Youth are twice as likely as adults to be victims of serious violent crimes.⁷
- Firearm-related homicide and firearm-related suicide accounted for 40 percent and 57 percent, respectively, of all firearm-related deaths in 2002.⁸
- Unintentional firearm-related fatalities also are a critical problem among children and young adults in the United States.⁸
- Nationally, nearly one in eight students has been in a physical fight on school property.⁹
- Nationally, 9 percent of students report being victims of dating violence.⁹
- Physical fighting can lead to serious injury and even death.¹⁰

HP 2010 Objectives:

- 15-32: Reduce homicides to no more than three people per 100,000.
15-38: Reduce physical fighting among adolescents to no more than 32 percent.
15-39: Reduce weapon carrying by adolescents on school property to no more than 4.9 percent.

Mental Health

(Depression, Suicide)

Positive mental health is an important component of overall physical health and well-being. It is a critical component in an adolescent's ability to establish relationships and reinforce good feelings about who they are and how they are perceived by others.

Adolescence is a time of life characterized by emotional ups and downs and vulnerability to mood swings and depression. Because mood disorders such as depression increase the risk of suicide, suicidal behavior is a matter of serious concern for families, school staff and mental health specialists.

- Nationally, one in six high school students seriously considered attempting suicide.⁹
- Among persons aged 15 to 19 years, firearm-related suicides accounted for 49 percent of the suicide deaths in 2002.¹¹
- There has been an increase in suicide rates for persons aged 15 to 19 years in the last 50 years (2.7 per 100,000 in 1950 to 7.4 per 100,000 in 2002), but a decrease in the last 20 years (8.5 per 100,000 in 1980 to 7.4 in 2002).¹²

HP 2010 Objectives:

- 06-02: Reduce the proportion of children and adolescents with disabilities, ages 4-17, who are reported to be sad, unhappy or depressed to no more than 17 percent.
- 18-01: Reduce the suicide rate to no more than five people per 100,000.
- 18-02: Reduce the rate of suicide attempts by adolescents in grades 9-12 to no more than 1.0 percent.
- 18-07: Increase the proportion of children with mental health problems who receive treatment.

Tobacco

Tobacco use can have serious long-term effects on health. Recent attention and strategies focused on preventing tobacco use in young people have led to a decrease in tobacco use among youth. The Morbidity and Mortality Weekly Report study on Tobacco Use Among Middle and High School Students – United States 2002 shows that cigarette, cigar, bidi and kretek smoking and tobacco use overall decreased from 2000 to 2002 among students in high school (i.e., grades 9-12), continuing a downward national trend since 1997.¹³ However, among middle school students there was no significant decline in tobacco use between 2000 and 2002.¹³ There is still much work to do to promote a non smoking culture in our younger population.

- Each day, approximately 4,000 youth aged 12-17 try their first cigarette – about one every 22 seconds.¹⁴
- The use of tobacco in youths is the “single leading preventable cause of death in the United States.”¹⁵
- Approximately 80 percent of tobacco users initiate use before age 18.¹⁵
- In addition, there is evidence that cigarette smokers are more likely to drink alcohol and use marijuana and cocaine as compared to non-smokers.¹⁶

HP 2010 Objectives:

- 27-02a: Reduce tobacco product use by adolescents to no more than 21 percent in grades nine-12.
- 27-02b: Reduce cigarette use by adolescents to no more than 16 percent in grades nine-12.
- 27-02c: Reduce spit tobacco use by adolescents to no more than 1 percent in grades nine-12.
- 27-02d: Reduce cigar use by adolescents to no more than 8 percent in grades nine-12.

Alcohol

Alcohol is one of the most commonly used substances during adolescence. Though underage drinking is against the law, alcohol may be easily accessible to many teens. Binge drinking (defined by the Youth Risk Behavior Survey as drinking five or more drinks within a couple of hours on at least one day in the past 30 days) can be especially dangerous as it may lead to other risky behaviors.

- Alcohol use among youth has been linked to unintentional injuries, physical fights, academic problems, job problems and illegal behavior.¹⁷
- Alcohol use has been identified as a major contributing factor in approximately one-third of all unintentional injury deaths, homicides and suicides which are the leading causes of death and disability among young people.¹⁸
- Underage persons who reported heavy drinking were 10 times more likely to report illicit drug use during the past month than underage persons who did not drink.¹⁹

HP 2010 Objectives:

- 26-10a: Increase proportion of adolescents not using alcohol or any illicit drugs during the past 30 days to 89 percent.
- 26-11d: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages to no more than 2 percent for teens aged 12-17 years.

Illegal Drugs and Prescription Drug Abuse

Understanding what motivates youth to experiment with illegal substances and prescription drugs requires a comprehensive look at the physical, emotional and social environment in which an adolescent lives. Illegal drug use and prescription drug abuse can lead to unhealthy behaviors and negative consequences. Drug abuse may contribute to depression and suicide, unintended pregnancy, school failure, violent behavior, delinquency and transmission of sexually transmitted diseases, including HIV infection.²⁰

- According to the Substance Abuse and Mental Health Services Administration Drug Abuse Warning Network, marijuana is the most frequently reported drug in emergency department visits related to drug abuse in youth aged 12 to 19.²¹
- Students aged 12 to 17 with positive school experiences were less likely to have used alcohol or illicit drugs in the past year than students without these positive school experiences.²²
- According to the 2002 National Survey on Drug Use and Health, the percentages of youth engaging in delinquent behaviors rose with increasing frequency of marijuana use.²²

HP 2010 Objectives:

- 26-10a: Increase proportion of adolescents not using alcohol or any illicit drugs during the past 30 days to 89 percent.
- 26-10b: Reduce the proportion of adolescents who report use of marijuana during the past 30 days to no more than 0.7 percent.

Sexual Behaviors

Since 1990, teen pregnancy and birth rates in the United States have declined significantly. Researchers cite two main factors: fewer teens are having sex, and among those who are, more are using contraceptives.²³ While this is a positive trend, there are still risks for those teens who are entering into sexual relationships during their adolescent years.

- The teen birth rate (births per 1,000 females ages 15-17) decreased from 39 in 1991 to 22 in 2003.²³
- Of the 19 million STD infections that occur annually, almost half of them are among youth ages 15 to 24.²⁴
- In 2003, 12 percent of all new HIV cases occurred in people ages 13 to 24. The majority of these infections were transmitted sexually.²⁵
- Higher numbers of sexual partners and unprotected sexual intercourse are associated with increased risk for STD and HIV infection.²⁶

HP 2010 Objectives:

- 09-07: Reduce pregnancies among adolescent females to no more than 43 per 1,000.
- 13-05: Reduce the number of cases of HIV infection among adolescents and adults. (Developmental)
- 25-01: Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections to no more than 3 percent.
- 25-11: Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active to 95 percent.

Nutrition

Obesity has reached epidemic proportions. In the past 20 years, the prevalence of obesity has increased by more than 60 percent among adults and tripled in children and adolescents. Approximately 16 percent of children and adolescents are overweight²⁷ and more than half of these children have at least one cardiovascular disease risk factor such as elevated cholesterol and hypertension.²⁸ Type 2 diabetes has become increasingly prevalent among children and adolescents.²⁷ This disease has traditionally been found in the adult population.

Developing healthy eating behaviors is necessary for adolescents to improve their health status. Nutrition education is critical so adolescents understand the importance of a balanced diet containing calcium and other nutrients rather than sugary drinks and high-fat snacks. Nationally, 78 percent of the adolescents reported eating fewer than five fruits and vegetables per day.⁹

- Americans currently consume about 33 percent of their total calories from fat.²⁹
- Overweight adolescents often become overweight adults with an increased risk for a wide variety of poor health outcomes including diabetes, stroke, heart disease, arthritis and certain cancers.³⁰
- Because lifetime dietary patterns are established during youth, adolescents should be encouraged to choose nutritious foods and to develop healthy eating habits.³¹
- Studies have shown high rates of body dissatisfaction and dieting among adolescent females, with many engaging in unhealthy weight control behaviors such as fasting and self-induced vomiting. Overemphasis on thinness during adolescence may contribute to eating disorders such as anorexia nervosa and bulimia. Adolescent females represent a high-risk population for the development of these two health problems and comprise 90 percent to 95 percent of all patients with eating disorders.³²

HP 2010 Objective:

19-03: Reduce the proportion of children and adolescents who are overweight or obese to no more than 5 percent.

Physical Activity

Lack of physical activity among youth can contribute to obesity. Many physical education programs in schools are severely limited. Therefore, daily physical activity is not something adolescents typically participate in unless they are involved in a sport or an intramural program. The Dietary Guidelines for Americans 2005 recommends that children and adolescents should engage in 60 minutes of moderate physical activity on most days of the week.³³

- Nationally, major decreases in vigorous physical activity occur during grades nine-12, particularly for girls. By 11th grade, more than half of female students are not participating regularly in vigorous physical activity.⁹
- Physical activity declines dramatically during adolescence. Nearly half of American youths 12 to 21 years of age are not vigorously active on a regular basis. Participation in regular physical activity helps build and maintain healthy bones and muscles, control weight, build lean muscle, reduce fat, reduce feelings of depression and anxiety and promote psychological well-being.³⁴
- In the long term, regular physical activity decreases the risk of dying prematurely, dying of heart disease and developing diabetes, colon cancer and high blood pressure.³⁴
- Nationally, daily participation in physical education class has dropped from 42 percent in 1991 to 28 percent in 2003.³⁴
- School physical education classes can increase student participation in moderate to vigorous physical activity and help students develop the knowledge, attitudes and skills they need to engage in lifelong physical activity.³⁵

HP 2010 Objective:

22-07: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness three or more days per week for 20 or more minutes to at least 85 percent.

Preventive Health Care

Nationwide, adolescents have the lowest utilization rate of health care services of any age group. Barriers to care include: cost of care; low family income; stigma; distrust; confidentiality and parental consent; lack of medical insurance; embarrassment about and lack of transportation to reproductive health services; lack of knowledge about where or how to access care; and lack of adolescent-friendly services.³⁶ To reduce the barriers to access to health care, it is critical for services to be available in a wide range of settings including community-based and school-based/linked services.

- Adolescents are less likely to have a medical home than younger children.³⁶
- Recent findings in the National Longitudinal Study of Adolescent Health indicate that each year one in five adolescents do not get health care even though they feel that they should. Among the adolescents who have foregone care, 63 percent reported “thinking the problem would go away,” 15 percent were unable to pay for it, 14 percent feared what they physician would say or do, 12 percent reported a parent or guardian would not accompany them, 11 percent had concerns about confidentiality and 9 percent had difficulty making an appointment.³⁷
- In 2002, 84 percent of adolescents (15-17) had one or more contacts with a physician or other health care professional compared with 94 percent of children younger than 5 years of age.³⁸

HP 2010 Objective:

There is no objective related to this issue.

Positive Youth Development

Positive youth development is the process of helping young people become successful youth and adults. Positive youth development is a philosophy as well as an approach that builds upon young people's assets and their strengths, enabling them to possess a higher threshold of resistance to temptations and unhealthy behaviors.

There are certain strategies and activities that need to be implemented to create positive environments in which to engage youth. Families, schools, neighborhoods, churches and community organizations can play a role in building positive environments and experiences for youth.

- Participation of youth in positive activities and the formation of close attachments to family, school and community have been linked to positive outcomes in research studies.³⁹
- Developmental Assets: Research from the Search Institute⁴⁰ has identified positive factors that help young people make good choices and grow up to be competent, caring and responsible adults. They can be grouped into eight categories:
 - Support – young people need to experience support, care and love from their families and many others. They need organizations and institutions that provide positive, supportive environments.
 - Empowerment – young people need to be valued by their community and have opportunities to contribute to others. For this to occur, they must be safe and feel secure.
 - Boundaries and Expectations – young people need to know what is expected of them and whether activities and behaviors are “in bounds” or “out of bounds.”
 - Commitment to Learning – young people need to develop a lifelong commitment to education and learning.
 - Social Competencies – young people need skills and competencies that equip them to make positive choices, to build relationships and to succeed in life.
 - Positive Values – young people need to develop strong values that guide their choices.
 - Positive Identity – young people need a strong sense of their own power, worth and promise.
 - Constructive use of Time – young people need constructive, enriching opportunities for growth through creative activities, including but not limited to youth programs, congregational involvement and quality time at home.

HP 2010 Objective:

There is no objective related to this issue.

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