

2010 TEEN HEALTH SURVEY

The 2010 Franklin County/North Quabbin Youth Risk Behavior Survey

Since 2003, the Community Coalition for Teens (CCT) has worked in partnership with area school districts, through the Regional School Health Task Force, to conduct an annual Teen Health Survey of 8th, 10th and 12th graders in schools in Franklin County and the North Quabbin. This document is a report of findings from the 2010 Teen Health Survey, based on almost 2000 responses from nine participating school districts: Athol-Royalston, Four Rivers Public Charter School, Franklin County Technical School, Frontier, Gill-Montague, Greenfield, Ralph C. Mahar, Mohawk Trail, and Pioneer Valley.

The survey instrument, the 2010 Franklin County/North Quabbin Youth Risk Behavior Survey (YRBS), was composed of 90 questions taken from the 2009 Massachusetts YRBS, and 11 questions designed locally by the Regional School Health Task Force.

The Massachusetts Department of Elementary and Secondary Education (DESE) administers the YRBS to a sample of high school students across the state every other year. The DESE-administered survey samples only a handful of students in Franklin County and the North Quabbin, so it does not provide detailed information about local student behavior.

The state survey can, however, be used as a point of comparison to

local findings. In this report, local 2010 data are compared to statewide data for 2009. Local and state findings are also compared to national YRBS data from 2009. Because the state and national YRBS are administered only to high school students, comparisons are possible only for 10th and 12th grade, not for 8th grade.

This report is divided into two sections. The first is a special feature on the importance of adults in the lives of young people. While not a surprising proposition that relationships with adults matter, recent research is illuminating the extent of adult influence on teen behavior. Data from the 2010 FC/NQ YRBS make a strong and consistent case that here in Franklin County and the North Quabbin, the important adults in teens' lives at home and at school are helping teens to make healthy choices.

The second section presents standard measures of risky behaviors used by the Centers for Disease Control and Prevention when reporting on YRBS findings. This section includes thirteen tables:

1. Unintentional injury
2. Weapons and violence-related behaviors
3. Fighting, bullying, sexual violence
4. Depression, suicidal ideation, self-injury

5. Tobacco
6. Alcohol
7. Illegal drug use
8. Sexual behaviors
9. Education about sexual health, STD testing
10. Obesity and overweight
11. Weight control
12. Diet
13. Physical activity

Each table presents results of the 2010 FC/NQ YRBS for 8th, 10th, and 12th grade, and compares 10th and 12th grade statistics to findings from the 2009 Massachusetts YRBS and the 2009 US YRBS. Following each table is a brief discussion of the rationale for examining the behaviors in the table, with citations to supporting research. This discussion is largely excerpted from CDC documentation for the YRBS.¹ On the tables, the state and national figures that are significantly different from the local figure are highlighted in bold.

When reviewing data in the tables, readers should keep in mind that this report, like YRBS reports for cities and states across the nation, uses conventional measures that emphasize risky behaviors. This is not the only possible perspective to take! For example, the finding that 21% of 10th graders smoked a cigarette in the 30 days before the survey means that 79% did not smoke. **For almost every behavior cited, most local young people are making healthy choices.**

The text, table and charts in this report represent only a portion of survey findings. Some of the 101 items on the questionnaire are not dis-

played in any of the tables, and others that are shown could have been displayed differently or analyzed in different ways.

The Community Coalition for Teens therefore invites community members to contact CCT with requests for additional information. Also available are:

- The 2010 YRBS questionnaire
- Cross tabulations for each question, by grade of respondent
- Additional analyses on request, such as responses by sex, race, or sexual orientation
- Data from Teen Health Surveys of 2003 through 2009. Reports on those surveys are posted on the publications page of the Franklin Regional Council of Governments website, <http://www.frcog.org/>

CCT does not release data about individual school districts. Requests for district-level data should be made to the district of interest.

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1. Youth Risk Behavior Survey (YRBS) Standard 2011 High School Questionnaire Item Rationale. www.cdc.gov/HealthyYouth/yrbs/pdf/questionnaire/2011_standard_itemrationale.pdf

Part One: The Important Role of Adults in the Lives of Teens

When we think about the choices young people make, we often think first about peer pressure and the influence of youth culture. Indeed, as young people enter their teen years, their relationships with their peers acquire new importance as sources of support and connection in their lives. But the rising importance of peers does not diminish the role of parents, teachers and other adults in their lives. Ideally, teens' relationships with adults evolve to allow for autonomy without sacrificing connection.

The 2010 Franklin County/North Quabbin YRBS includes two simple questions that allow us to gauge local teen-adult connections:

- Can you talk with at least one of your parents or other adult family members about things that are important to you?
- Is there at least one teacher or other adult in this school that you can talk to if you have a problem?

Happily, by far the majority of local young people have adults in their lives they can talk to. Eighty-three percent say they can talk with a parent or other adult at home, and 73% say they have an adult at school to turn to if they have a problem. Two-thirds (66%) have adults to talk to both at home and at school.

The percent of local young people who say they have an adult to talk to at home is remarkably consistent for both boys and girls and across

grade levels. As for teen-adult relationships in school, 12th graders are the most likely to say they have an adult to talk to (80%, as compared to 72% of 8th graders and 69% of 10th graders), and girls are slightly more likely than boys to report having an adult to talk to (85% vs. 80%).

The YRBS data also allow us to compare statistics for young people who say they have an adult to talk with to statistics for those who say they do not. We see a striking and consistent pattern that teens who have adults in their lives are far less likely to engage in risky behaviors, and more likely to do well in school.

The National Research

Local findings are fully consistent with recent national research that illuminates just how critical teen-adult connections are for teens' healthy development:

- In 2003, researchers at ETR Associates received funding from the Annie E. Casey Foundation to study the construct of Parent-Child Connectedness. They found that a mutual and sustained emotional bond between parents and children is a "super-protector" that can help young people negotiate life's challenges. Parent-Child Connectedness has been linked to a wide variety of outcomes for teens, with multiple studies showing an impact on school achievement and on prevention of risky sexual behavior, violence and drug use.¹

- A 2010 survey of 1500 parents and teens conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University used six questions to create an index of the strength of family ties. CASA found that, compared to families with strong family ties, teens in families with weak family ties are four times as likely to have tried tobacco, almost three times as likely to have tried alcohol, and four times as likely to have tried marijuana.²
- Teen-adult relationships at school are also critically important, as demonstrated by research over the past several years on “School Connectedness,”—the belief by students that adults in the school care about their learning as well as about them as individuals. Using data from the federally-funded National Longitudinal Study of Adolescent Health, researchers examined the impact of protective factors on the health and well-being of more than 36,000 7th-12th graders and found that School Connectedness was the strongest of all protective factors in decreasing substance use, school absenteeism, early sexual initiation, violence and risk of unintentional injury. School Connectedness is also strongly associated with educational outcomes, including attendance, staying in school, grades and test scores.³
- A 2009 Search Institute study of 1860 15-year-olds examined several dimensions of teen relationships with adults beyond the family. As compared to teens who

scored low on the relationship index, those who scored high were more than twice as likely to work up to their ability in school, more than three times as likely to have a sense of purpose and hope for their future, and almost three times as likely to believe it is important for them to be involved in community issues.⁴

The Search Institute study concludes, “Teens need adults in their lives who listen to them, laugh with them, guide them, and love them. Parents or other primary caregivers are, of course, the most critical. But teens also need positive, sustained, and meaningful relationships with extended family members, teachers, mentors, grandparents, neighbors, and many others.”⁵

The data in the charts on the following pages show just how true this is here at home as it is across the nation.

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1. Lezin, Nicole, Rolleri, Lori A., Bean, Steve, Taylor, Julie. *Parent-Child Connectedness: Implications for Research, Interventions, and Positive Impacts on Adolescent Health*. ETR Associates, 2004. www.etr.org/recapp/documents/research/
 2. National Center on Addiction and Substance Abuse at Columbia University. *National Survey of American Attitudes on Substance Abuse XV: Teens and Parents*, August 2010. www.casacolumbia.org/upload/2010/20100819teensurvey.pdf
 3. Centers for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors Among Youth*. Atlanta, GA: U.S. Department of Health and Human Services; 2009. www.cdc.gov/HealthyYouth/adolescenthealth/pdf/connectedness.pdf
 4. Peter C. Scales, Ph.D., Eugene C. Roehlkepartain, and Peter L. Benson, Ph.D. *Teen Voice 2009: The Untapped Strength of 15-Year-Olds*. Best Buy Children’s Foundation and Search Institute. www.search-institute.org/system/files/TeenVoiceReport_FINAL.pdf
 5. *Ibid.*, p. 15.

The Local Data

In the charts below, the green bars show responses for students who say they have an adult to talk with, and the red bars show responses for students who say they do not. For each item, the impact of having an adult at school is shown on the left, and the impact of having an adult at home is shown on the right.

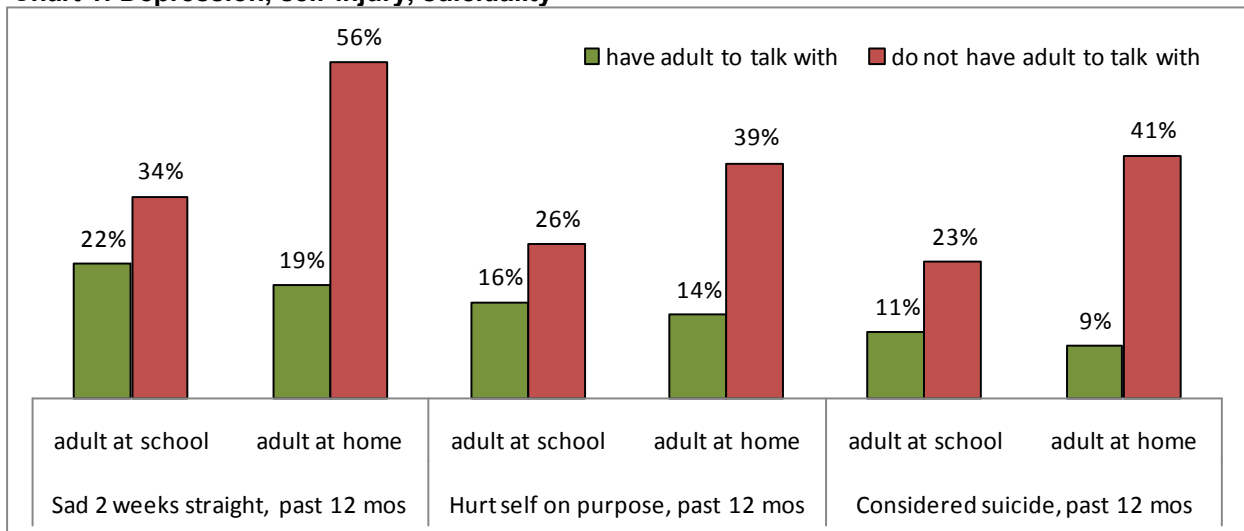
For example, Chart 1 shows that 22% of students who have an adult to talk to at school said they had depressive feelings (“felt so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities”), while 34% of students who do not have an adult to talk to at school acknowledged depressive feelings. And 19% of students who have an adult to talk to at home said they had depressive feelings, as compared to 56% of those who report they cannot talk with an adult at home about important things. That means students who do not have an adult to talk to at home are three times more likely to report depressive feelings than their peers.

Chart 1 also shows a similar pattern for self-injury and an even stronger association for considering suicide. Students without an adult at home to talk to were 4.6 times more likely to say they had considered suicide than their peers.

The pattern evident in Chart 1 holds for every behavior examined: local students with adults to talk to are much less likely to engage in risky behaviors than students who do not have adults to talk to. The pattern is particularly arresting in the comparison of those who do and do not have an adult at home to talk to about important things.

There are limitations to these data. The associations shown here do not prove causation, so, for example, we cannot say from our data alone that having an adult at home to talk to dramatically reduces teens’ risk of depression. And the two questions in the YRBS about having adults to talk to are incomplete measures of the quality of teen-adult connections. But when we take the national research on Parent-Child Connectedness and

Chart 1: Depression, self-injury, suicidality



School Connectedness into account, we can reasonably see these data as a reflection of the importance of an adult presence as a powerful protective factor in the lives of young people.

Charts 2, 3, and 4 show that, compared to their peers, local students who do not have an adult to talk to at home are 2.5 times more likely to have smoked cigarettes, twice as likely to have used marijuana, and 56% more likely to have used alcohol in the 30 days preceding the survey. The association with presence of an adult at school is almost as strong. Teen-adult relationships also appear to be highly protective against early initiation of substance use.

Chart 2: Cigarette smoking

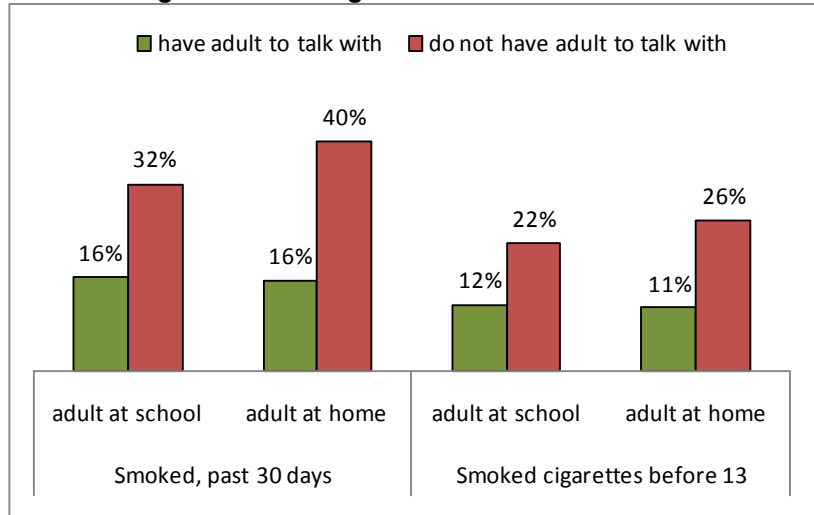


Chart 3: Marijuana use

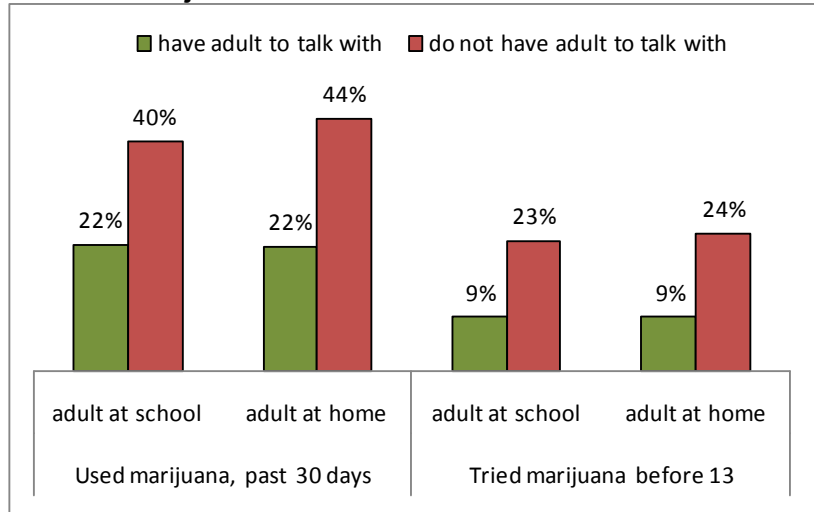
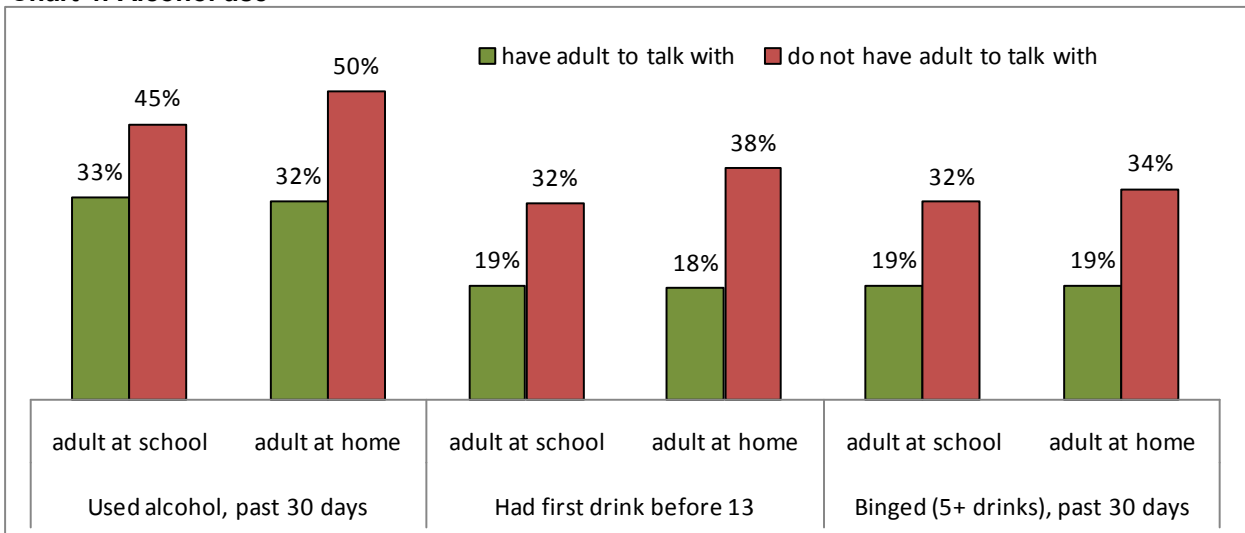


Chart 4: Alcohol use



The 2010 FC/NQ YRBS data suggest that teen-adult connections provide the greatest protection for the riskiest behaviors.

Charts 5 and 6 show sharp contrasts for experimentation with “hard” drugs and recreational use of prescription drugs. The table to the right shows that, as compared to students who have adults to talk to, students who do not are three, four, and even six times as likely to have tried various hard drugs.

Students who do not have an adult to talk to at <u>school</u> are:		
2.9 . . .	times more likely to have used...	. . .cocaine
2.8 . . .	times more likely to have used...	. . .ecstasy
4.0 . . .	times more likely to have used...	. . .methamphetamines
Students who do not have an adult to talk to at <u>home</u> are:		
4.0 . . .	times more likely to have used...	. . .cocaine
3.9 . . .	times more likely to have used...	. . .ecstasy
6.0 . . .	times more likely to have used...	. . .methamphetamines

Chart 5: Use of illicit drugs

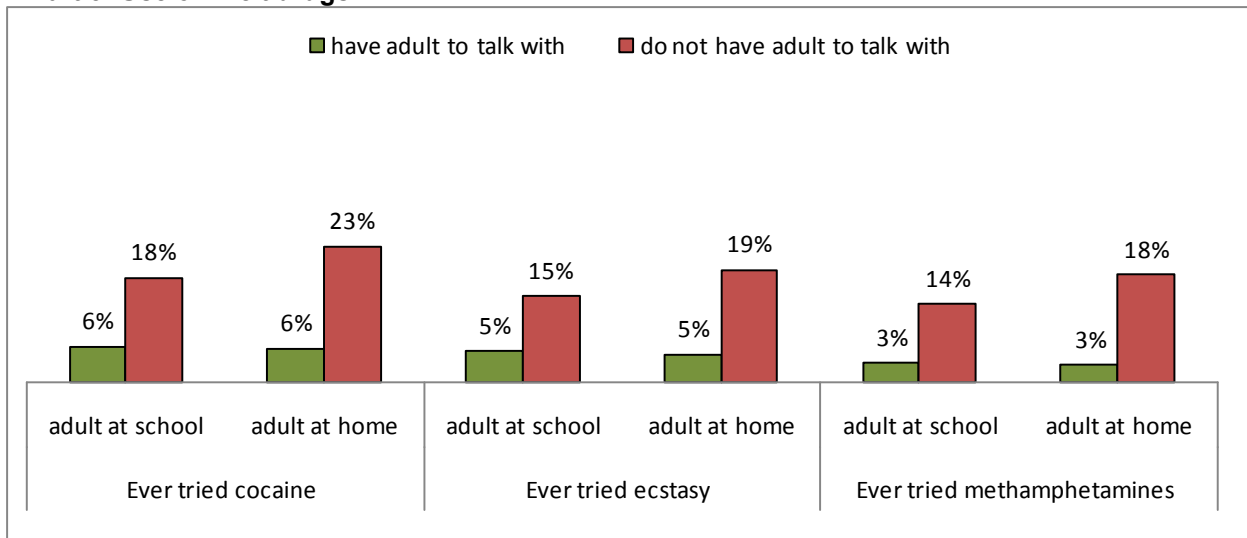


Chart 6: Recreational use of prescription drugs

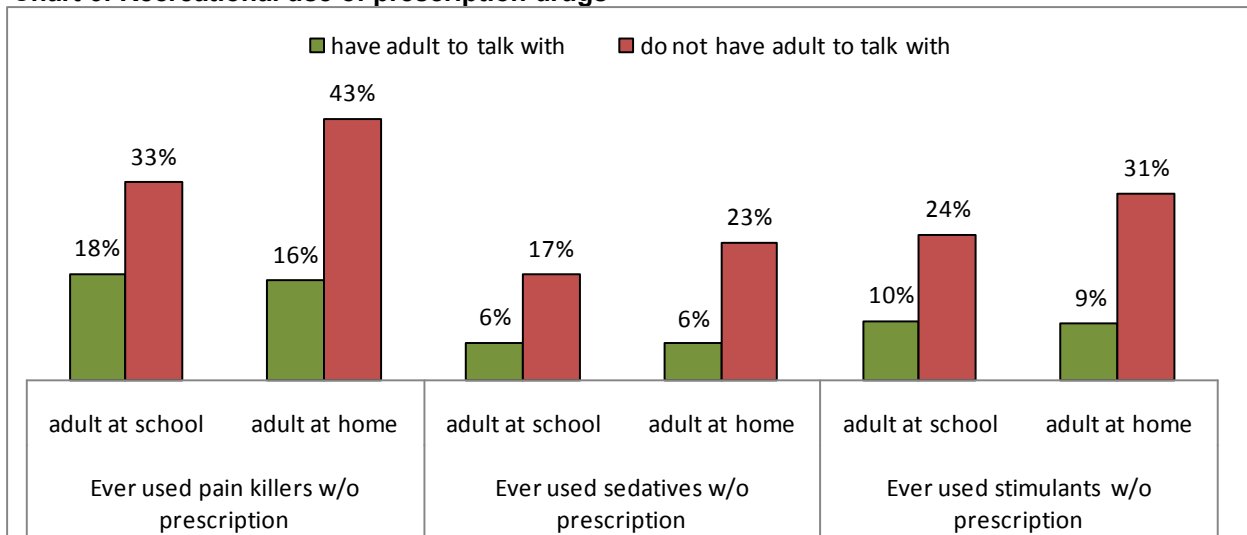


Chart 7 suggests that teen-adult relationships, particularly those at home, are highly protective against drinking and driving.

Charts 8 and 9 show the associations between having adults to talk to and behaviors at school. Interestingly, while connections at school are very important, connections at home appear to matter most in influencing behaviors at school. For example, it's striking that, as compared to their peers who say they can go to an adult at school if they have a problem, students who do not have an adult at school to talk to are 2.4 times more likely to smoke at school. And even more striking: students without an adult to turn to at home at home are 3.8 times more likely than their peers to smoke at school.

Chart 7: Alcohol and driving

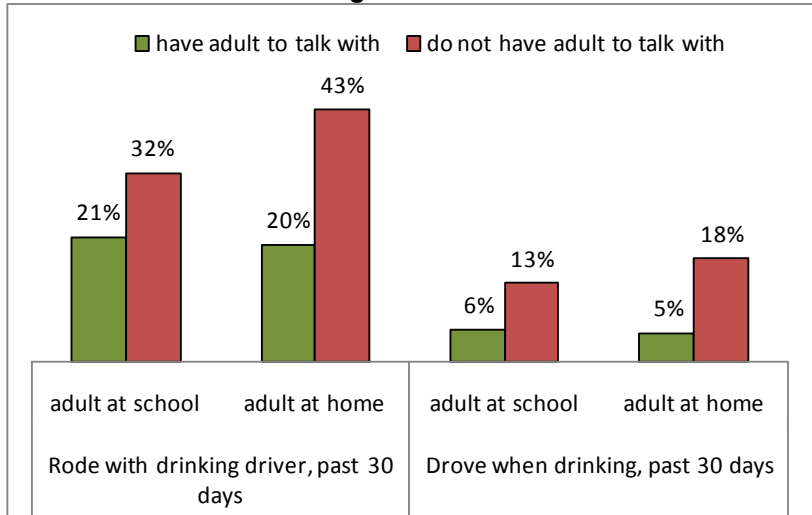


Chart 8: Weapons and fighting at school

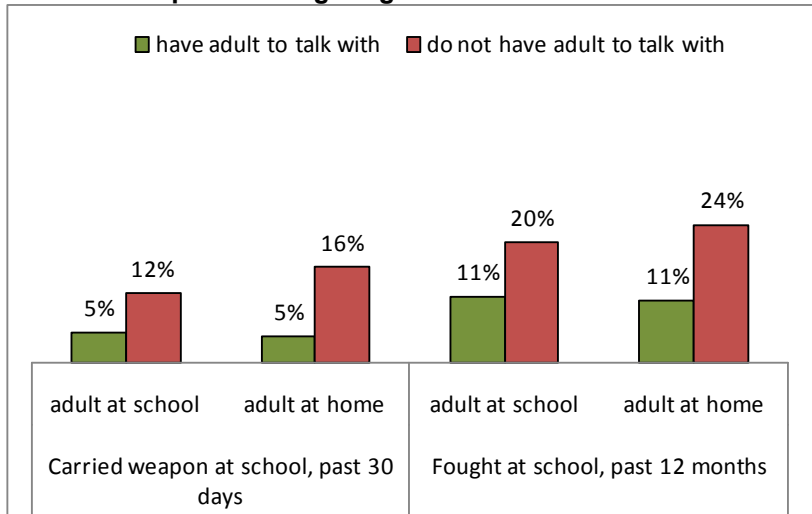
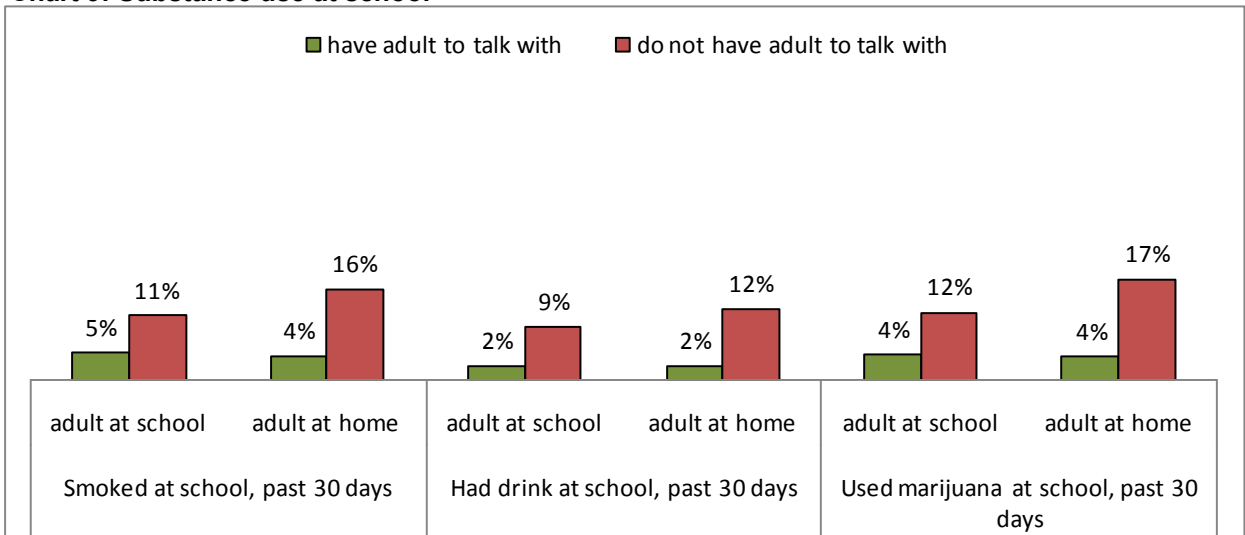


Chart 9: Substance use at school



According to 2010 FC/NQ YRBS data, students who have adults to talk to and students who do not are equally likely to be of normal healthy weight, based on self-report of height and weight. But, compared to their peers, normal-weight students who do not have an adult to talk to at home are 65% more likely to say they believe they are overweight. Chart 10 shows that students without an adult to talk to at home are also far more likely than their peers to use unhealthy weight loss methods: 3.6

times as likely to have fasted, 3.5 times as likely to have taken diet pills, and 4.9 times as likely to have vomited to lose weight.

Chart 11 shows the associations between having adults to talk with and sexual behaviors, with the strongest associations evident for the riskiest behaviors. Students without an adult to talk to at home are 2.2 times more likely than their peers to have had sex before 13 and nearly twice as likely to have had four or more partners.

Chart 10: Unhealthy weight loss methods

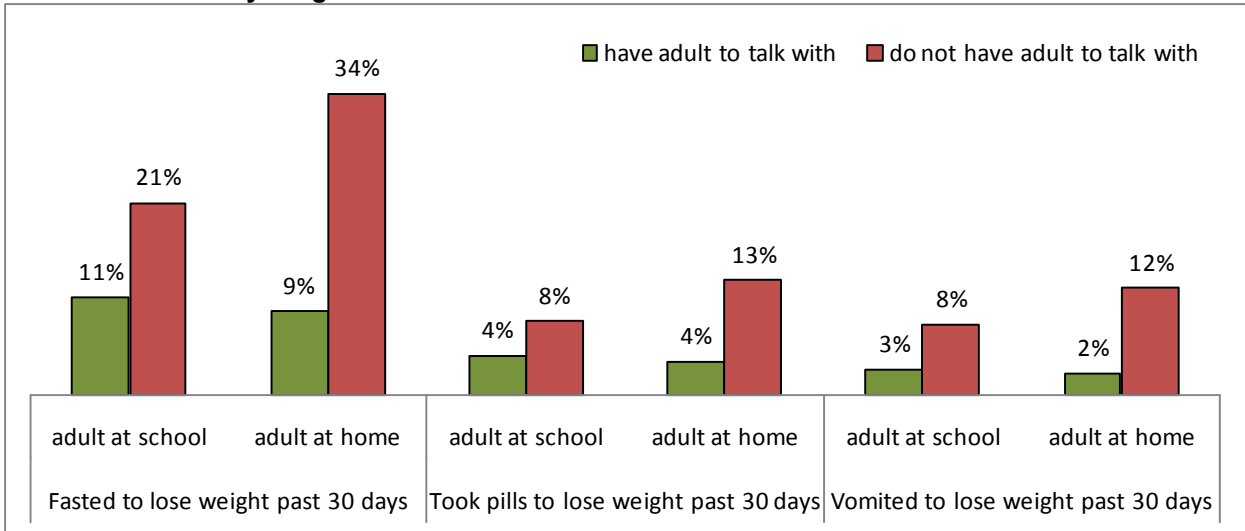


Chart 11: Sexual behaviors

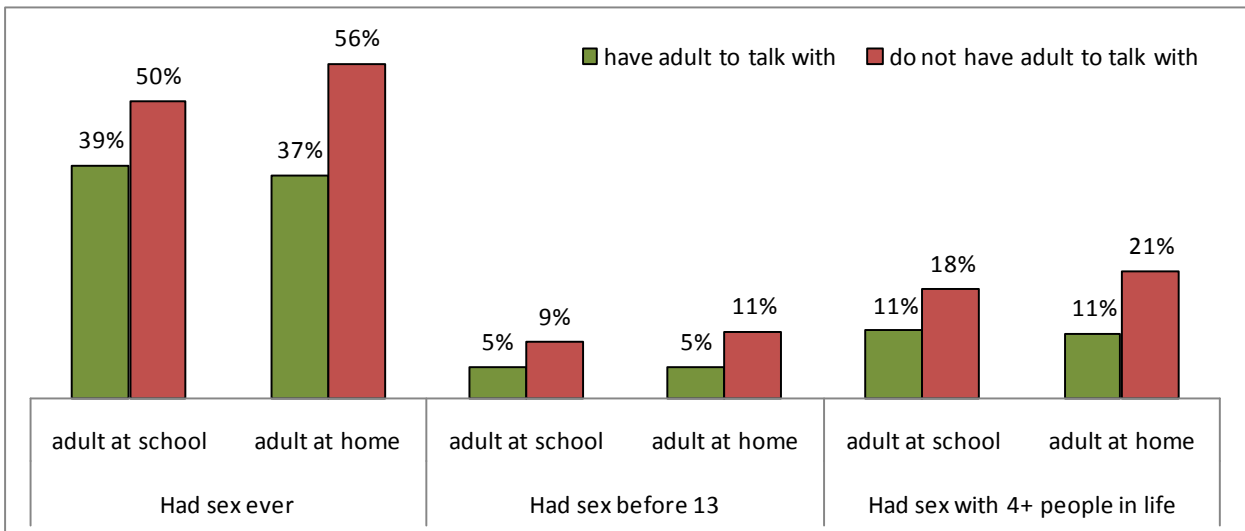


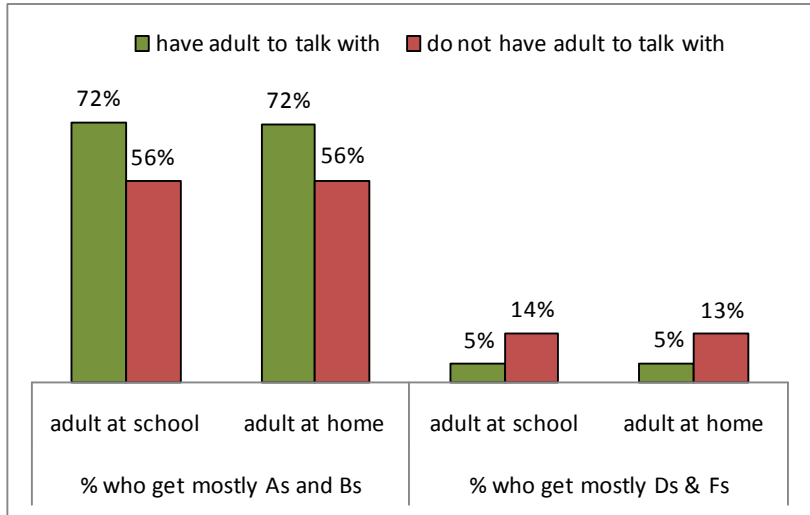
Chart 12 displays connections between having adults to talk to and self-report of grades in school. Here the associations are almost identical for adult support at school and at home. Students with adults to talk to are 28% more likely to say they get mostly As and Bs in school, and far less likely to report Ds and Fs.

The 2010 FC/NQ YRBS provides vivid evidence of the ways local young people are benefiting from the presence of caring adults in their lives. Clearly, it is important for young people to feel they have adults to talk to about the things that matter to them.

And adults can do more. Based on 20 years of research on “developmental assets” — the positive factors in teens’ lives that support healthy development — the Search Institute suggests fifteen actions adults can take to support young people:¹

- Ask teens about things that are important to them.
- Give them time, if they haven’t yet identified the issues they care deeply about.
- Introduce them to others who share their commitments.
- Believe in them, even when they may not believe in themselves.
- Help them figure out the next step for moving forward.
- Challenge negative perceptions about teens when you hear them.

Chart 12: Grades in school



- Link them with people of multiple generations.
- Focus on their “sparks” — the things that excite them — and encourage teen voice in youth programs.
- Engage them in their sparks in school projects and give them a voice in school.
- Find out what gets in their way when they’re stuck.
- Don’t impose your ideas on them.
- Tap them as volunteers and leaders in the community.
- Introduce them to new interests and issues.
- Help them prioritize and focus.
- Support them every step of the way.

1. Peter C. Scales, Ph.D., Eugene C. Roehlkepartain, and Peter L. Benson, Ph.D. Teen Voice 2009: The Untapped Strength of 15-Year-Olds. Best Buy Children’s Foundation and Search Institute. P. 33-34. www.search-institute.org/system/files/TeenVoiceReport_FINAL.pdf

Part Two: Data Tables

Part Two consists of 13 data tables presenting data for 8th, 10th and 12th graders on most of the topics included in the survey. In the tables, local data from the 2010 Franklin County/North Quabbin YRBS are compared to 2009 state and national data. Comparisons are made for 10th and 12th graders only. The state and national surveys were administered to high school students, not middle school students, so there is no point of comparison to local 8th graders. In the tables, state and national statistics that are significantly different from local statistics are highlighted in bold. Following each table is a brief discussion of the rationale for examining the behaviors in the table, with citations to supporting research.

As mentioned in the introduction to this report, readers should keep in mind as they review the data tables that there is, in fact, good news presented here. These tables follow the CDC and state conventions for reporting data, which emphasize how many young people are engaging in risky behaviors. The good news is on the flip side: **For almost every behavior cited, most local young people are making healthy choices.** For example:

- Most local young people (81%) do not smoke cigarettes.
- Most local young people (75%) do not use marijuana.
- Most local young people (65%) do not drink alcohol.
- Most local young people have never tried hard drugs like cocaine (92%), ecstasy (93%), or methamphetamines (95%).
- Most local young people (93%) do not drink and drive.
- Most local young people (70%) have not been in a fight in the past year.
- Most local young people (88%) wear seat belts.
- Most local young people (79%) are of normal, healthy weight.
- Most local young people (79%) have been taught in school about how to eat a balanced, nutritious diet.
- Most local young people (61%) eat breakfast most days of the week.
- Most local young people (81%) drink soda less than once a day.
- Most local young people (56%) have been taught in school about how to follow a personal fitness plan.
- Most local young people (58%) get at least 20 minutes of intense aerobic activity most days of the week.
- Most local young people (60%) have been on a sports team in the past year.

Table 1: Unintentional injury

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Rarely or never wore a seatbelt	11.9	9.4	9.8	12.4	10.1	17.3	11.5
Rode with a driver who had been drinking alcohol, past 30 days	18.1	28.0	26.0	25.4	28.2	32.7	25.8
Drove after drinking alcohol, past 30 days	2.4	8.3	6.0	5.3	15.4	16.7	14.0

Motor-vehicle related injuries kill more young people ages 5-19 years than any other single cause in the United States.¹ Safety belts, when used appropriately, reduce the risk of fatal injury to front-seat passenger car occupants by 45% and the risk of moderate-to-critical injury by 50%.²

Almost a third (31%) of 15- to 20-year-old drivers who were killed in motor vehicle crashes in the United States during 2008 had been drinking, and a quarter (25%) had a BAC of .08 or higher.³ Moreover, drivers are less likely to use restraints when they have been drinking. In 2008, of the young drivers who had been drinking and were killed in crashes, 73% were unrestrained.⁴

Nationally, these risky behaviors have declined significantly since the inception of the YRBS in 1991. In the most recent data shown here, local 10th graders are significantly less likely to say they drove after drinking alcohol than their peers across the nation. Other differences observed here are not statistically significant.

Table 2: Weapons and violence-related behaviors

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Carried a weapon, past 30 days	14.8	18.4	12.4	17.8	16.6	12.8	18.4
Carried a gun, past 30 days	3.2	6.1	2.5	5.3	6.2	3.9	6.7
Carried a weapon at school, past 30 days	3.3	6.1	3.5	7.1	6.0	5.0	9.5
Skipped school because felt unsafe, past 30 days	4.4	5.0	3.5	3.8	3.4	4.0	6.0
Was threatened or injured with a weapon at school, past 12 months	6.8	8.4	6.0	8.2	5.2	4.7	8.2
Was member of a gang, past 12 months	4.2	N/A	TBA Oct 2010	5.7	N/A	TBA Oct 2010	9.3

Homicide is the second leading cause of death among all youth ages 15-19 years (9.6 per 100,000).⁵ Firearms intensify violence and increase the likelihood of fatality in a conflict.⁶ In 2006, 85% of homicide victims 15-19 years old were killed with firearms.⁷

Almost all of the nation's school districts have a policy prohibiting weapon possession or use by high school students on school property,⁸ but the latest national YRBS shows that about 6% of high school students carried a weapon to school at least once in the 30 days preceding the survey.

Nationally, the percentage of young people who said they had carried a weapon decreased in the 1990s, and then remained steady since 1999. The differences here between local figures and state and national figures are not statistically significant.

Table 3: Fighting, bullying, sexual violence

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Was in a physical fight, past 12 mos.	33.0	33.5	29.3	30.1	24.9	26.8	24.4
Was in a physical fight and required medical treatment, past 12 mos.	4.2	4.1	2.9	5.0	2.9	3.6	4.2
Was in a physical fight at school, past 12 mos.	14.4	12.1	9.5	13.9	6.6	7.3	9.5
Bullied on school property, past 12 mos.	30.9	21.5	18.7	19.7	13.5	13.6	15.0
Of those who have dated, have ever been physically hurt by a date	11.1	N/A	TBA Oct 2010	12.9	N/A	TBA Oct 2010	11.8
Was ever subject to sexual contact against their will	5.6	N/A	TBA Oct 2010	9.3	N/A	TBA Oct 2010	11.0

Physical fighting is a marker for other problem behaviors⁹ and is associated with serious injury-related health outcomes.¹⁰

Bullying victimization is associated with depression, suicidal ideation, repeated common health problems, school absenteeism, psychological distress, and feeling unsafe at school.¹¹

Nationally, the percentage of students saying they had been in a fight decreased from 1991-2003, and then leveled off. Local young people report levels of fighting and bullying that are similar to those of their peers across the state and nation.

Table 4: Depression, suicidal ideation, and self-injury

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Felt sad/hopeless for 2 weeks in past 12 mos.	20.9	26.1	23.0	25.7	24.3	25.0	25.9
Seriously considered suicide, past 12 mos.	11.4	13.4	13.0	13.4	12.1	12.1	14.0
Suicide attempt required medical attention, past 12 mos.	1.1	2.2	2.4	1.7	1.2	2.0	2.4
Cut or hurt self on purpose without wanting to die, past 12 mos.	17.6	N/A	TBA Oct 2010	21.5	N/A	TBA Oct 2010	13.5

Suicide is the third leading cause of death among the nation's youth ages 15-19 years.¹²

Research has shown that childhood depression often persists, recurs and continues into adulthood, especially if it goes untreated. The presence of childhood depression also tends to be a predictor of more severe illnesses in adulthood.¹³

The percentage of US high school students who seriously considered attempting suicide has decreased by half since the first YRBS measurement in 1991. The percent reporting feeling sad or hopeless has remained fairly constant. Levels of depression and contemplating suicide in the local area are similar to levels state and nationwide.

Table 5: Tobacco

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Ever tried cigarettes	28.3	44.0	39.1	41.7	55.5	52.2	50.9
Smoked a whole cigarette before age 13	12.5	11.2	7.9	13.4	8.6	9.9	13.2
Current (past 30 days) cigarette smoking	12.6	18.3	14.6	20.9	25.2	20.7	25.0
Smoked cigarettes on school property, past 30 days	2.4	4.7	6.1	6.3	6.5	8.5	9.6
Current (past 30 days) smokeless tobacco	3.3	8.1	7.7	11.0	10.0	10.0	12.8
Current (past 30 days) cigar use	6.1	13.2	13.6	16.6	18.5	21.0	21.9
Current (past 30 days) use of any tobacco	14.5	24.5	21.0	28.9	33.1	31.4	35.7

Cigarette smoking is the leading cause of preventable death in the United States, and it increases risk of heart disease, chronic obstructive pulmonary disease, acute respiratory illness; stroke, and cancers.¹⁴ Use of smokeless tobacco products increases the risk of developing cancer of the mouth, heart disease and stroke.¹⁵

The percent of American high school students who are current cigarette smokers has dropped nearly by half since 1997. The differences here between local figures and state and national figures are not statistically significant.

Table 6: Alcohol

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Lifetime alcohol use	46.2	71.1	69.9	70.3	79.7	80.5	76.8
Had first drink before age 13	23.0	22.2	16.0	21.5	14.2	15.3	17.6
Current (past 30 days) alcohol use	19.6	40.6	41.8	38.5	51.7	53.2	50.2
Binge drinking, past 30 days	8.4	22.3	21.7	21.9	33.5	35.6	35.3
Drank alcohol on school property, past 30 days	1.5	4.8	3.1	3.6	4.1	6.0	5.5

Alcohol is used by more young people than tobacco or illicit drugs.¹⁶ Heavy alcohol drinking among youth is associated with risky sexual behaviors¹⁷ and use of cigarettes, marijuana, cocaine, and other illegal drugs.¹⁸ Young people who begin drinking alcohol before they are 15 years old are five times as likely to report alcohol dependence or abuse than those who first drank alcohol at age 21 or older.¹⁹

Alcohol use by American high school students has gradually declined in the past decade. The FC/NQ 2010 YRBS shows local alcohol use rates to be similar to rates for the state and the nation.

Table 7: Illegal drug use

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Lifetime marijuana use	21.1	35.5	38.3	47.0	45.6	54.7	55.8
Tried marijuana before age 13	10.6	8.3	8.5	12.3	5.2	9.5	11.3
Current (past 30 days) marijuana use	11.9	21.1	24.9	30.1	24.6	35.2	34.3
Used marijuana on school property, past 30 days	2.5	4.6	5.2	5.9	4.6	8.1	9.4
Lifetime cocaine use	3.9	5.6	5.0	9.9	7.9	9.9	12.0
Lifetime ecstasy use	2.4	5.2	4.4	8.4	8.0	9.7	10.9
Lifetime methamphetamine use	2.1	3.7	2.4	6.8	4.1	3.9	7.3
Lifetime illegal steroid use	1.7	3.4	2.4	6.0	3.1	4.6	4.6
Was offered, sold, or given drugs on school property, past 12 months	12.0	23.7	27.2	27.7	20.6	25.4	21.2

Illicit drug use by young people is associated with heavy alcohol and tobacco use²⁰, violence and delinquency²¹, and suicide.²² All of the nation's school districts prohibit illegal drug possession or use by students on school property.²³

The 2010 FC/NQ YRBS shows local marijuana use rates to be higher than rates for the nation as a whole. A relatively high proportion of local young people also said they had tried other drugs at least once in their lives.

Table 8: Sexual behaviors

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Ever had sexual intercourse	17.5	40.9	40.3	43.0	62.3	66.2	65.6
Had sexual intercourse before age 13	5.2	6.5	4.3	6.4	4.4	5.4	5.7
Had four or more sexual partners in lifetime	3.2	11.7	10.5	12.5	20.9	21.7	23.7
Currently sexually active (past 3 months)	11.3	29.1	27.7	30.9	49.1	52.2	54.5
Of sexually active, used a condom at last intercourse	68.4	67.8	63.3	65.7	55.0	50.1	57.1
Of sexually active, used alcohol or drugs at last intercourse	24.7	22.4	27.9	28.9	20.2	20.9	28.5
Have ever been pregnant or gotten partner pregnant	1.4	N/A	TBA Oct 2010	3.7	N/A	TBA Oct 2010	11.8

Early initiation of sexual intercourse is associated with having a greater number of lifetime sexual partners.²⁴ In addition, adolescents who initiate sexual intercourse early are less likely to use contraception²⁵ and are at higher risk for pregnancy.²⁶

The 2010 FC/NQ YRBS statistics for sexual behaviors of local young people are similar to statistics for the state and the nation.

Table 9: Education about sexual health, STD testing

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Was taught in school about AIDS or HIV infection	73.2	87.3	89.7	84.2	89.3	89.1	90.7
Was taught in school how to use condoms	38.5	N/A	TBA Oct 2010	65.7	N/A	TBA Oct 2010	77.3
Ever been tested for HIV	5.4	N/A	TBA Oct 2010	7.3	N/A	TBA Oct 2010	18.4
Ever tested for other STDs	4.1	N/A	TBA Oct 2010	7.0	N/A	TBA Oct 2010	18.4
Ever told by a medical professional that they have HIV or other STD	1.1	N/A	TBA Oct 2010	1.5	N/A	TBA Oct 2010	3.3

According to the July 2010 National HIV/AIDS Strategy for the United States, “educating young people about HIV before they begin engaging in risk behaviors that place them at risk for HIV infection should be a priority.”²⁷

Recent estimates suggest that, while representing 25% of the ever sexually active population, young people ages 15-24 years acquire nearly half of all new STDs, and many are not aware they are infected.²⁸ More than 50% of HIV-infected adolescents do not know their infection status.²⁹

The CDC recommends making HIV testing a routine part of health care for adolescents and adults aged 13–64 years to reduce the spread of HIV.³⁰ Early identification of HIV infection enables people to start treatment sooner, leading to better health outcomes and longer lives.

Table 10: Obesity and overweight

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Overweight (\geq 85 th but $<$ 95 th BMI-for-age percentile)	12.2	16.9	16.4	12.8	14.7	12.6	9.7
Obese (\geq 95 th BMI-for-age percentile)	9.4	11.0	10.6	9.3	13.5	9.9	8.1
Described self as slightly or very overweight	30.4	25.9	28.8	30.5	30.6	28.1	32.5

Data on self-reported height and weight is used to calculate body mass index (BMI) and determine the corresponding BMI-for-age percentile for adolescents. BMI-for-age percentile is a proxy measure of weight status, correlates with body fat, and is recommended for assessing weight status in youth ages 2-20.³¹ Although BMI calculated from self-reported height and weight underestimates the prevalence of obesity compared to BMI calculated from measured height and weight³², self-reported height and weight are useful for tracking BMI trends over time. Obesity during adolescence is associated with negative psychological and social consequences and health problems such as type 2 diabetes, obstructive sleep apnea, hypertension, dyslipidemia, and metabolic syndrome.³³ Further, obese adolescents are more likely to become obese adults.³⁴

In the past decade, obesity has increased significantly among the nation's young people. The 2010 FC/NQ YRBS shows rates of obesity and overweight among local high school students to be lower than rates for the nation as a whole.

Table 11: Weight control

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Exercised to lose weight/avoid weight gain, past 30 days	65.1	61.1	60.7	63.9	62.3	54.2	60.8
Ate less to lose weight/avoid weight gain, past 30 days	39.5	38.9	39.3	38.7	42.1	41.5	39.6
Fasted 24+ hours to lose weight/avoid weight gain, past 30 days	10.6	10.3	8.2	14.2	9.9	8.3	12.7
Took diet pills to lose weight/avoid weight gain, past 30 days	2.8	4.4	4.2	5.0	5.6	7.7	7.4
Vomited or took laxatives to lose weight/avoid gain, past 30 days	1.8	3.7	5.0	4.3	3.4	5.3	5.0

Current recommendations promote healthy eating and physical activity as effective weight control behaviors.³⁵ Unhealthy weight control behaviors include fasting, taking diet pills or laxatives, or inducing vomiting. Engaging in unhealthy weight control behaviors may result in physical and psychological health problems such as obesity, eating disorders such as anorexia and bulimia, and stunted growth.³⁶ Disordered eating behaviors are correlated with inadequate nutrient intake, low self-esteem, high levels of depression, suicidal ideation, high levels of stress, and alcohol and drug use.³⁷

The 2010 FC/NQ YRBS shows fasting to be more prevalent among local youth than among their peers across the nation; the difference for 10th graders is statistically significant.

Table 12: Diet

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Was taught in school about choosing foods for healthy diet	77.7	N/A	TBA Oct 2010	80.3	N/A	TBA Oct 2010	79.8
Eat breakfast most days of the week	65.5	N/A	TBA Oct 2010	59.7	N/A	TBA Oct 2010	56.5
In past 12 months, have gone hungry in one or more months because family lacked food or money to buy more	7.4	N/A	N/A	10.9	N/A	N/A	11.3
Drink soda less than once a day	82.2	70.8	78.6	80.3	71.7	79.7	80.1
Drink sports drinks or other sweetened drinks less than once a day	81.1	N/A	N/A	77.2	N/A	N/A	74.5

Healthy eating contributes to overall healthy growth and development, including healthy bones, skin, and energy levels; and a lowered risk of dental caries, eating disorders, constipation, malnutrition, and iron deficiency anemia.³⁸

Research suggests that not having breakfast can affect children's intellectual performance.³⁹ Hunger and food insufficiency in children are associated with poor behavioral and academic functioning.⁴⁰

Consumption of sugar sweetened beverages is associated with increased risk of overweight, a less healthy diet, decreased bone density, and dental decay.⁴¹

The questions about going hungry and about sports drinks were unique to the FC/NQ survey, so there is no state or national point of comparison. Local young people are less likely to drink soda daily than their peers across the nation.

Table 13: Physical activity

	8th grade	10th grade			12th grade		
	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ	2009 U.S.	2009 MA	2010 FC/NQ
Active for 60+ minutes/5 days of past week	37.9	39.3	36.8	37.9	31.6	27.7	33.7
Attend a physical education class at least once/wk	73.3	57.6	68.2	68.8	43.8	54.6	62.6
Attend physical education classes daily	25.4	33.7	23.5	16.7	22.4	21.0	27.8
Played on at least one sports team, past year	61.2	61.8	61.7	60.3	51.1	50.7	56.7
Watch three or more hours of television per day	26.0	34.7	30.8	27.6	29.7	28.2	25.9
Play on computer three or more hours per day	32.1	25.5	32.8	33.5	21.2	27.8	31.9
Was taught in school how to follow a physical fitness plan	50.8	N/A	TBA Oct 2010	58.6	N/A	TBA Oct 2010	60.3

Participation in regular physical activity can help young people build and maintain healthy bones and muscles, maintain body weight and reduce body fat, reduce feelings of depression and anxiety, and promote psychological well-being.⁴² In 2008, the U.S. Department of Health and Human Services recommended that young people ages 6–17 participate in at least 60 minutes of physical activity daily.⁴³ School physical education classes can increase adolescent participation in physical activity and help high school students develop the knowledge, attitudes, and skills they need to engage in lifelong physical activity.⁴⁴

Watching TV and using a computer are considered sedentary behaviors. Among youth, time spent watching TV, in particular, is associated with childhood and adult obesity and youth who engage in less than two hours of TV viewing per day tend to be more active.⁴⁵

As compared to their peers across the nation, a greater proportion of local high school students play on the computer three or more hours a day, and a smaller proportion spend three or more hours watching TV. The table above also shows that local 12th graders are significantly more likely to attend at least one physical education class a week than American 12th graders as a whole, and 10th graders are less likely to attend physical education classes daily than American 10th graders as a whole.

2010 Franklin County/North Quabbin Youth Risk Behavior Survey (FC/NQ YRBS) n=1999

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