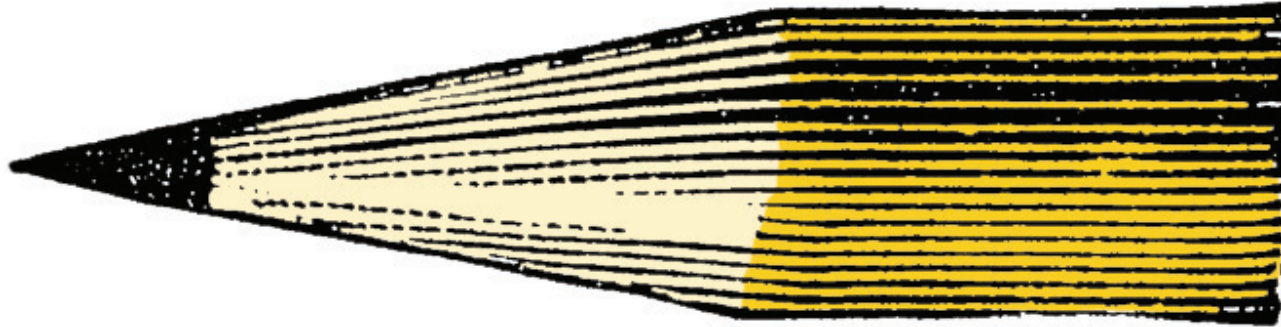


GUIDEBOOK TO THE

CALIFORNIA

healthy kids

SURVEY



PART II: SURVEY CONTENT – SUPPLEMENTAL MODULES

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WestEd 



school climate, health & learning
CALIFORNIA SURVEY SYSTEM

The California Healthy Kids Survey—along with the California School Climate Survey and the California School Parent Survey—is part of the comprehensive Cal-SCHLS data system, developed for the California Department of Education.

Contents

ALCOHOL AND OTHER DRUG USE, VIOLENCE AND SAFETY MODULE	1
Preface.....	2
Alcohol & Other Drug Use.....	3
Violence & Safety.....	8
References	15
Tables.....	18
TOBACCO MODULE.....	22
Preface.....	23
Tobacco Use	24
References	30
Tables.....	32
PHYSICAL HEALTH MODULE	34
Preface.....	35
Physical & Mental Health.....	36
References	45
Tables.....	47
SEXUAL BEHAVIOR MODULE	49
Preface.....	50
Sexual Behavior	51
References	58
Tables.....	61

Alcohol and Other Drug Use, Violence and Safety Module

Preface

This section of your California Healthy Kids Survey (CHKS) report provides additional information from supplementary Module C concerning substance use and violence-related behaviors.

- » The information on substance use includes frequency of use in the past six months and use patterns and cessation efforts
- » The violence and safety-related items are less focused on the school environment than in the Core Module and include suicide.

The questions were selected for their value to help improve programs funded under the federal Safe and Drug Free Schools and Communities Act (Title IV). Most of them were derived from the biennial, state-mandated California Student Survey (CSS).

An index links by number the report tables to the instrument questions, and also provides references to the tables on substance use and violence in the main CHKS report (Core Module).

The complete dataset of results is available electronically on request. We encourage additional analyses of the results, particularly in regard to four areas: (a) characteristics of youth most involved in health risk behavior; (b) how behaviors vary among subgroups of youth; (c) how behaviors may be related; and (d) what factors are most associated with them. This will help in targeting prevention and intervention efforts to those in most need.

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Alcohol & Other Drug Use

This first section is designed to promote a better understanding of the patterns and dynamics of alcohol and other drug (AOD) use and the factors that need to be taken into consideration in program planning. It covers:

- » the frequency of recent AOD use in the past six months;
- » high-risk behavior, such as heroin use, poly drug-use;
- » involvement in selling drugs;
- » cessation efforts and intervention needs.

FREQUENCY OF USE IN THE PAST SIX MONTHS

HS Questions C1-8/MS Questions C1-4: During the past six months, about how many times have you used these substances without a doctor's orders?

Tables C1-C7 report the frequency with which students used seven categories of psychoactive substances over the six months prior to the survey.¹ These six-month prevalence items serve four main purposes:

- » They identify what proportion of students are recent users even if they did not use in the 30 days before the survey, the standard indicator of current use (see Table A3.2).
- » They include more categories of use that are assessed for the past 30 days and ask about alcohol use in general rather than a “drink.”²
- » They provide a perspective on how regularly students are using each substance—whether occasionally, about once per month, once per week, or daily.³
- » They expand the comparability of the results to national norms. The 6-month prevalence rates are roughly comparable to 12-month rates from other surveys, such as Monitoring the Future, the National Household Drug Abuse Survey, or the American Alcohol and Drug Survey. Analysis of 1997 CSS data revealed that youth recall of marijuana use over the past 6 months does not differ significantly from the past 12 months.⁴

Monthly Use

The frequency of AOD use once a month or more often rises markedly after 7th grade. Recent CSS data show that monthly drinking (any alcohol) has increases fivefold or more between grade 7 and grade 11, and marijuana use sixfold. In 2001, monthly drinking rose from 3% to 26% between grades 7 and 11.

Compare these rates with the proportion of respondents who reported any use in the past 30 days (Table A3.3). This provides an indication of how many current users were regular monthly users for half a year. In the 1999 CSS, two

1 In addition to alcohol, marijuana, and inhalants, high school students are asked about cocaine, methamphetamine, LSD/psychedelics, and heroin.

2 See the discussion of heroin use in the section on drug injection.

3 Table A3.2 does not provide a sense of how these days were distributed over the month, it only shows any use.

4 1997 Marijuana report.

thirds of current drinkers in 11th grade reported drinking every month over the past half year. Four-fifths of current marijuana users in 11th grade reported this same behavior. Those CSS respondents drinking at least once a month were also likely to be using once a week.

Weekly Use

Tables C1-7 also provide the proportion using once or more each week, an indication of involvement in a regular drug-use lifestyle and risk for an escalation of use-related problems. CSS data show that weekly use is almost entirely limited to alcohol and marijuana, but that these weekly users reported significantly higher rates of use-related problems than students who used less frequently. Trends in weekly use of these substances also vary in parallel with overall prevalence. Weekly use is more common for alcohol than for marijuana, but the difference between these drugs narrowed in the early 1990s as overall marijuana use rose. This suggests that reducing overall prevalence rates may also help reduce the proportion of regular users.

Daily Use

The proportion of students who used every day in the past six months should be compared with current daily-use, which is based on using 20 or more days in the past month. The CSS has consistently shown that marijuana is the most widely-used substance on a daily basis, except for cigarettes. Still, only 3% of 9th graders and 6% of 11th graders reported daily marijuana use in the 2001 CSS. Daily use of alcohol was even more rare—reported by only 2% in 11th grade.

Polydrug Use

Table C7 reports on the frequency in the past six months that high school students engaged in polydrug use, or using two or more drugs together at the same time (for example, using alcohol with marijuana, or cocaine with pills). Polydrug use is especially risky because of the adverse pharmacological interactions that can result from combining substances, a danger that should be emphasized in drug education classes. Because marijuana is the most popular illicit drug among adolescents, the polydrug use prevalence and trends are often similar to those for marijuana. In the 2001 CSS, polydrug use was reported by 24% in grade 11.

OTHER PATTERNS OF USE

Steroid Use (Past 12 Months)

HS Question C9: During the past year, have you taken any steroid (roids) to build up muscle or increase performance or endurance?

HS Question C10: During the past year, have you taken any banned performance-enhancing supplement that claims to build muscle or increase strength or endurance (andro, ephedrine, DHEA)?

Table C8 and C9 presents the self-report from high school students of whether during the past 12 months they had illegally (that is, without a doctor's orders) used steroid pills or injections. Overall, a relatively small proportion of secondary students report lifetime steroid use, only 5% in the 2001 YRBS, but the rate among males is almost twice as high as females. Anabolic steroids are synthetic substances related to male sex hormones. They are used legally to treat delayed puberty, impotence, and body wasting in patients with AIDS and other diseases. Athletes and bodybuilders may take them to build muscles, reduce body fat, and improve sports performance. As with excessive dieting and physical activity, steroid use among adolescents may be an indicator of issues with body image.

Because steroids have valid medical uses, they are often thought to be legal and safe. In fact, the potential health consequences of steroid abuse are disruptions in the hormonal system and growth among adolescents; cardiovascular, liver, and skin diseases; infections from injections including HIV/AIDS and hepatitis B and C; and increased aggressive behavior. Moreover, steroids used outside the care of a physician are not regulated for quality, which adds to the health risks.

High levels of use may indicate a lack of understanding on the part of students and staff about these adverse consequences. Because of their association with body-building and sports performance, sports programs are a likely target for intervention and staff development.

DRUG AVAILABILITY AND SELLING

The Core Module (Table A3.20) reports on the proportion of students who thought it was easy to obtain alcohol and marijuana. The AOD, Violence, and Suicide Module assesses the sources of alcohol and drugs—from who and where adolescents obtain them—and the respondents' own involvement in the drug distribution network. CSS data show the distribution of drugs has, for many years, been integrated into adolescent culture; it is a facet of adolescent social interchange. In this sense, drugs are self-maintaining rather than something imposed from the outside. Youth resistance to drug prevention and intervention efforts is more understandable in this light.

Sources for Alcohol

HS Question C16: How do most kids at your school who drink alcohol get it? (Mark all that apply.) (A) At school. (B) At parties or events outside school. (C) At their own home. (D) From adults at friends' homes. (E) From friends or another teenager. (F) Get adults to buy it for them. (G) Buy it themselves at a store (convenience store, liquor store, grocery, mini mart). (H) Other. (I) Don't know.

Table C13 reports the results of a new item on the 2003-04 survey on how respondents think their peers get alcohol. Although a companion to item C21 on drugs, this question asks about “how” they get alcohol instead of “where” they get drugs because in many cases the source of alcohol is a person rather than a place. Thus while many of the response options on the two items are the same, many are different, including “Get adults to buy it from them” and “Buy it themselves from a store.” This question was added because of the continued prevalence of drinking among California students and to provide data to support the Department of Alcohol and Drug Programs new federally-funded initiative targeting reduction in underage drinking.

Selling Drugs

HS Question C19: During the past 12 months, how many times have you sold drugs to someone?

Table C16 reports the proportion of high school students who engaged in selling drugs in the twelve months prior to the survey.⁵ CSS data indicate that only a minority of high school students are involved in drug-selling, but that most of these respondents report selling on multiple occasions.

- » In the 1999 CSS, 7% of 9th and 14% of 11th graders had sold drugs one or more times. Over half of these 9th-grade youth sold more than once, as did over three-quarters of the 11th-graders. Indeed, in 11th grade more than half of them reported four or more instances.

⁵ Because of the low prevalence of drug sales in the 7th grade, this item was deleted in 2003 from the middle-school survey.

Much of this activity may be informal, in the sense of small-scale sharing with reimbursement among peers, rather than large-scale dealing as employees of criminal organizations. The total CSS percentages for drug sales have been about two to three times higher among lifetime drug users than for the general student population, depending on grade and survey year.

CESSATION EFFORTS AND NEED FOR HELP

HS Questions C11-12: How many times have you tried to quit or stop using...alcohol? ...marijuana?

HS Question C13: Have you ever felt that you needed help (such as counseling or treatment) for your alcohol or other drug use?

Tables C10 and C11 provide the proportion of high school respondents that ever tried to quit using alcohol or marijuana. (The Tobacco Module asks about the proportion who tried to quit smoking.) These results help in assessing the need for intervention services, such as student assistance programs, support groups, and referrals to treatments. Cessation efforts need to be encouraged and supported.

CSS results indicate that relatively few high school alcohol drinkers make even one effort to stop using alcohol, with little change (at about 24% in 2001) or even a slight decline (as in 1999) in cessation-attempt rates with age, although drinking prevalence increases with age. This reflects the endemic nature of drinking in youth culture. In contrast, cessation-attempt rates for marijuana are higher than for alcohol (although not as high as for cigarettes) and increase with grade (40% in 9th to 45% in 11th grade), suggesting a substantial number of students may be open to intervention.

The CHKS also asks high school students if they ever felt they needed help for their AOD use, such as treatment or counseling, as reported in Table C12. This provides additional information on the dynamics of cessation and potential treatment need. CSS results have shown only very small percentages answer “yes,” far below the number who report ever trying to stop use. This could reflect denial. The results need to be examined in the context of the survey data on the frequency and level of use, as well as on reported problems and cessation attempts. You should also take into consideration the proportion who mark “don’t know” to needing help, because these youth probably at least contemplated that they might need help (they didn’t answer “no”).

- » In the 2001 CSS, 3% of 11th graders had felt they needed help, and 8% marked “don’t know,” similar to the results in 1999.

SCHOOL POLICIES AND PROGRAMS

HS Question C15. In your opinion, how likely is it that a student will be suspended, expelled, or transferred if he or she is caught on school property using or possessing alcohol or other drugs?

HS Question C14. In your opinion, how likely is it that a student would find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?

MS Question C6. During the past 12 months, did you receive any information or education about using alcohol or other drugs in any of your school classes?

To shed light on perceptions toward prevention programs and policies, high school students were asked about the likelihood of getting punished or helped for AOD-related behavior, as reported in Tables C14 and C15. If students

do want help, do they perceive that it is available to them? High school students were asked how likely it would be that a student who wanted to stop using alcohol or other drugs would find such help at school. CSS results have consistently indicated that relatively few high school students think it likely. If a high proportion respond “don’t know,” it may mean that fewer students may perceive a need for assistance because they either do not use or have not had negative experiences associated with use.

- » In the 2001 CSS, only one fifth of 9th graders and 13% of 11th graders thought it very likely that help would be provided. The most frequently selected option is “not likely,” by about half of students.

To shed further light on student perceptions of the school environment, high school students were also asked about the likelihood that a student would be suspended, expelled, or transferred for using or possessing alcohol or other drugs at school.⁶ In the CSS, about half thought it was very likely and about an additional quarter thought it likely, possibly a legacy of “zero tolerance” pushing out assistance in favor of punitive policies. This suspension question was added to link the survey data to school policies and also help fulfill the data requirements of No Child Left Behind.

In a new item, middle school students were asked if they received any information or education about using alcohol or other drugs in any of their school classes in the past 12 months (Table C19). Compare these results with your school data on service delivery. Are they consistent?

⁶ HS C15. “In your opinion, how likely is it that a student will be suspended, expelled, or transferred if he or she is caught on school property using alcohol or other drugs?”

The Core Module asks key questions about violence and safety in the school environment (because this is a school-based survey). The AOD, Violence, and Suicide Module asks more about violence-related behavior in general. Safety is not just a school problem. The violence that occurs there is a mirror of the community as a whole.⁷

INVOLVEMENT IN FIGHTING (PAST 12 MONTHS)

Tables C17 and C18 provide the annual (past 12 months) frequency of physical fights and of fighting among groups. These questions about fighting can reflect either aggression or victimization (responding to provocation). Either way, they provide an indication of the overall climate of physical violence. (Table A5.2 provides results for the frequency of being in a physical fight at school.)

Frequency of Physical Fights

HS Question C20/MS Question C7: During the past 12 months, how many times have you been in a physical fight?

Physical fighting (Table C17) is of concern because of the obvious potential for injury and harm, regardless of culpability. Physical fights, if unresolved, can lead to more serious conflicts involving weapons. Both the CSS and YRBS show that physical fighting is the most commonly reported violence-related behavior. In contrast to the increasing rates of drug use that occurs across these grades, reported fighting declines with grade. This may reflect maturation, or that violent youth drop out or are expelled from school before the 11th grade.

- » In the 2001 CSS, physical fighting was reported by 27% of 7th graders, 24% of 9th graders, and 19% of 11th graders, an increase among high school students compared to 1999.
- » In the 1999 YRBS, it was reported by 36% of secondary students nationwide, declining from 41% in 9th to 31% in 11th grades.

Group Fights

HS Question C21/MS Question C8: During the past 12 months, how many times have you been in a physical fight between groups of kids?

Table C18 presents the frequency of participation “in a physical fight between groups of kids.” Group fighting is an indicator of social conflict and/or disarray. It is a different, and arguably more serious, level of violence than that indicated by physical fighting between individuals. Group fighting is also likely to be a public- and peer-centered form of violence that can be more physically and emotionally threatening to greater numbers of students. It can thus lead youth to greater levels of violence than an individual conflict.

Assessing the prevalence of group fights also helps provide a sense of potential gang violence. You can examine the proportion of students who reported being in group fights that also belonged to a gang (see Table A5.8) to demonstrate the violent culture of gang life. CSS results indicate that half of students in gangs report engaging in a group fight more than once (vs. 30% of the total sample).

⁷ Previously, the AOD, Violence, and Suicide Module also asked students whether they had been arrested by the police or sheriff, for any reason, in the 12 months prior to the survey. This was deleted in 2003/04 to help reduce the size of the module because data on arrests are available from local police.

Data Analysis Suggestion. Examine the overlap between youth who reported being in physical fights and those who reported being in group fights. Are they the same youth? To shed light on the potential social causes of group fights, examine what proportion reported being threatened, bullied, or harassed (see Tables A5.1-5.2). Also, in order to help target prevention efforts to those most in need, analyze variations in this behavior across demographic groups of students.

WEAPONS POSSESSION AND USE

The Core Module contains several questions that ask about the frequency with which guns and other weapons are carried and seen on school property in the past 12 months. The AOD, Violence, and Suicide Module provides additional data on more recent weapons possession in general, or at school, as well as data on how these weapons are used.⁸

Carrying Weapons in the Past 30 Days

HS Questions C25-27, MS C12-14. During the past 30 days, on how many days did you carry...a gun? ...any other weapon (such as a knife or club)? ...any weapon (gun, knife, or club) on school property?

Table C24 reports the number of days youth reported carrying a gun or any other weapon in the past 30 days.⁹ According to the CDC, homicide is the second leading cause of death among all youth aged 15-24 and is the leading cause of death among black youth.¹⁰ Approximately nine out of ten homicide victims in the United States are killed with a weapon of some type.

- » In the 1999 YRBS, 17% of secondary students reported carrying any weapon, and 5% a gun. Rates were only slightly less in the upper grades than in the lower. Gender had a far more significant affect on rates than age—males are five times more likely to have carried a weapon in the past month than females.

Compare the results for carrying weapons in general to the number of days that students reported carrying weapons on school property in the same period (see Table C25).¹¹ This will provide an indication of how weapons possession in both environments are related and can help to galvanize school and community collaboration to eliminate this

8 Previously, the CHKS AOD, Violence, and Suicide Module also asked a question about how easily youths believe they can obtain a gun if they wanted to get one. This was deleted in 2003/04 as part of the effort to keep the survey modules as short as possible. However, we strongly recommend that districts who have found high levels of gun carrying among their students include this item in a custom module. Student involvement in shootings—whether accidental or intentional—can only occur when guns are available. The immediate accessibility of a firearm or other lethal weapon often is the factor that turns an altercation into a lethal event. Firearms are also involved in 60% of adolescent suicides. There is little specific information available about how readily accessible guns are to adolescents. However, nearly one half of all households nationally have a gun in them. The availability of firearms and the firearm homicide rate have increased since the late 1950s. While a few studies report no association between firearm availability and violence, more studies show a positive relationship. This appears to be especially true among aggressive youth, for whom it has been argued that the mere exposure to guns can exaggerate violent tendencies. Aggressive youths are also known to have had greater exposure to the violence enmeshed within mass media.

9 This item was included in the Core module in 2001 and 2002, in order to promote comparisons with the YRBS, from which this question was derived. However, in order to keep the number of questions on the Core module to an absolute minimum, in 2003 it was changed to this supplement. Previous versions of the survey also asked about carrying a weapon and then any weapon, including a gun. The latter response option was changed to “any other weapon” to be able to identify the proportion of students who carried weapons other than a gun in the past 30 days.

10 Murphy (1999).

11 This item was included in the Core module in 2001 and 2002, in order to promote comparisons with the YRBS, from which this question was derived. However, in order to keep the number of questions on the Core module to an absolute minimum, in 2003 it was changed to this supplement. Previous versions of the survey also asked about carrying a weapon and then any weapon, including a gun.

problem. Every major study in the field has found that youths carry weapons more frequently outside of school than at school.

- » On the YRBS, weapons possession at school has been 3 to 4 times less frequent than outside of school.

Gun possession is known to be much higher among youths with a history of delinquency, gang membership, and other disorders of conduct.¹² Whenever a youth demonstrates extremely aggressive behavior it is advisable to gather additional information about any past involvement in gangs, violent offenses, drug selling, and ownership or easy access to firearms. Youths with this kind of delinquency profile are more likely than non-delinquent youths to use guns for self-protection and to bring a gun to school.

- » In the 1997 CSS, the rate of weapons possession at school among 11th graders was about four times greater among gang members than non-gang members. In addition, it was almost three times as great among 11th graders who were high risk drug users compared to conventional drug users (and over 10 times as high compared to abstainers). Finally, weapons possession was 3.5 times greater among youth at high risk of poor school adjustment compared to those at low risk.¹³

Use of Weapons to Bully or Threaten

HS Question C22/MS Question C9: During the past 12 months, how many times have you used any weapon to threaten or bully someone?

It is important to understand the reasons why youth carry weapons and how they use them. Some youth may use weapons for bullying. In the 1997 CSS, about one third of the high school students who took a weapon to school reported threatening someone at least once, but others may carry them because of fears over personal safety (protection). Youth often justify carrying weapons because they erroneously believe this will prevent fights and make them safer. To shed light on this issue, CHKS respondents were asked how often they used a weapon to threaten or bully someone in the past 12 months, as reported on Table C19.

Compare these results with the proportion of students that reported being threatened or injured with a weapon at school in Table A5.6. Together, these two items provide insight into the adverse impact of weapons on youth safety both in and out of school.

GAMBLING

HS Question C18/MS Question C6. During the past 12 months, how many times have you...gambled (bet) for money or valuables in any way?

HS Question C17/MS Question C5 During the past 12 months how many times have you gambled (bet) for money or valuables in any way?

In response to concerns about increasing youth involvement in gambling or gambling-related activities, this item was added to the survey in 2003/04, as reported in Table C20 and C21. It has been estimated that one out of three

The latter response option was changed to “any other weapon” to be able to identify the proportion of students who carried weapons other than a gun in the past 30 days.

12 Cornell and Loper (1998); Callahan (1993).

13 Austin, Huh-Kim et al. (1999).

or four adolescents is a problem gambler. Problem gambling is a serious addiction, a progressive disease under the DSM. It is highly correlated with suicide attempts.

SAFETY

School Days Missed Due to Feeling Unsafe

HS Question C24/MS Question C11: During the past 30 days, on how many days did you not go to school because you felt unsafe at school or on your way to or from school?

Students can't learn if they are afraid to go to school. The Core Module provides data on student perception of how safe they felt in their schools (Table A5.11). Table C23 reports the number of days out of the past 30 that respondents actually did not go to school because they felt unsafe at school or on the way to or from it. Derived from the YRBS, this question provides an indication of how concerns about safety affect school attendance. If a high proportion of students miss school because of safety concerns, this demonstrates how important violence prevention is to efforts to improve school performance. By assessing perceived safety while going to and from school, this question also provides information useful for fostering school-community collaboration in reducing violence.

- » In the 1999 YRBS, 5% of secondary students nationally missed at least one day of school because of safety concerns, with the rate dropping from 7% of 9th graders to 4% of 11th and 12th graders.

Data Analysis Suggestion. Compare the results with the perceived school and neighborhood safety in Tables A5.11 to provide a more complete picture of the student perceptions of their environment's safety.

Perceived Safety of Neighborhood

HS Question C23/MS C10: How safe do you feel in the neighborhood where you live?

Table C22 reports how safe students felt when they were in their neighborhood. This is an indicator of the overall impact of violence and harassment in the lives of youth, especially the psychological harm represented by fear and anxiety. It is important to look at both school and neighborhood environments, for often youth report feeling safer in school than away from it, or in traveling back and forth from it.

In 2003-04, along with the perceived school safety question (HS A82/MS A74), the response options for this question were modified to add a mid-point of "Neither safe nor unsafe." This was done based on feedback that indicated many youth find it difficult to choose between schools or neighborhoods being "very safe/safe" vs. "unsafe/very unsafe."

Comparison Data. In the CSS, the great majority of youth—over eight out of ten—have consistently felt both their school and neighborhood were safe or very safe. The rates in 2001 for schools ranged across grades from 81% to 86%; for the neighborhood, they were around 87% in each grade. The higher rates for neighborhood safety may reflect feelings about the family and student perceptions that they have more control over certain people or places in the community than at school.¹⁴

¹⁴ As with the school safety item, a mid-point response option was added to this question in 2003. This item was not included in the 2003 CSS in order to make room for additional questions relating to the characteristics of heavy AOD use.

Suicide Ideation

In 1997, 1.5 times as many people died from suicide than from homicide. The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide increases steadily through the teens.¹⁵ Suicide is now the third leading cause of death among adolescents aged 15 to 19.¹⁶ The extent to which this problem has grown in past decades has been subject to much debate. While the suicide rate for the general population has remained stable since 1950, it has increased among adolescents 15 to 19 years old by more than 300%. However, it has been argued that much, if not all, of this increase has been a result of more accurate reporting of cause of death.¹⁷

The following questions were part of the optional CHKS AOD, Violence, and Suicide Module and may not have been administered to all students.

As reported in Tables C27-C29, the CHKS asks three questions relating to suicide that were derived from the YRBS: whether students ever considered, planned, or attempted suicide in the 12 months prior to the survey.¹⁸ High school students were also asked if any suicide attempt resulted in an injury, poisoning, or overdose that required medical attention.

Contemplating Suicide

HS Question C28: During the past 12 months, did you ever seriously consider attempting suicide?

MS Question C15: During the past 12 months, did you ever think about killing yourself?

In the 1999 YRBS, the annual suicide contemplation rate was 19% for high school students nationwide, with little grade differences.¹⁹ Significant gender differences exist: females are about twice as likely as males to report suicide-related behaviors. For example, 25% of females in the 1999 YRBS reported seriously considering suicide, compared to 18% of males. Females also are more likely to attempt suicide than males.²⁰

Planning Suicide

HS Question C29: During the past 12 months, did you make a plan about how you would attempt suicide?

MS Question C16: During the past 12 months, did you make a plan about how you would like to kill yourself?

If a student reports not just considering suicide but making a plan, the risk for suicide is much greater. The level of risk in having made a plan is similar to that of verbal communication of intent to commit suicide, one of the best predictors of suicide.²¹ An expression of verbal intent in response to a direct question can be a warning of a possible plan or method of occurrence of possible suicidal behavior.²²

15 U.S. Department of Health and Human Services (1990).

16 Hoyert, D. L. et al. (2001).

17 Males, M. A. (1996), p. 225.

18 In a related item, the Core Module A asks students whether they had felt so sad or hopeless almost every day for two weeks or more in the past year that it stopped them from doing some usual activities (Table A6.8).

19 Males, M. A. (1999), p. 235.

20 National Center for Health Statistics (1995).

21 Maris, R. (1996).

22 Shea (1998).

Attempting Suicide

HS Question C30: During the past 12 months, how many times did you actually attempt suicide?

MS Question C17: Have you ever tried to kill yourself?

HS Question C31: If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?

A past history of suicide attempts is another critical risk factor for eventually committing suicide.²³ If a suicide attempt results in an injury that requires medical treatment, it indicates the degree of seriousness of the attempt. High lethality in previous attempts correlates with increased current risk level.²⁴ According to the National Household Survey on Drug Abuse, of the nearly 3 million youth aged 12 to 17 who thought about suicide in 2000, 37% actually tried to kill themselves.²⁵

- » In the 1999 YRBS, the suicide-attempt rate 8%, less than half that for contemplating suicide. Although there was little difference by grade for contemplating, the attempt rate dropped from 10% in 9th grade to 6% in 11th grade.²⁶

If females appear more likely to think about and attempt suicide, US vital statistics reveal that males are much more likely to succeed in suicide. Males are four times more likely to die from suicide than are females.²⁷

FORCED SEX

HS Question C32/MS Question C18: Have you ever been forced to have sexual intercourse when you did not want to?

This question about ever being forced to have sexual intercourse (as reported in Table C26) was derived from the YRBS and sheds light on patterns of violence and victimization related to sexual behavior.²⁸ There is a false assumption implied in many pregnancy prevention programs that all teenage sex is voluntary, yet nearly 60% of adolescents report at least one episode of dating violence, and 20% that they had experienced forced sex.²⁹

- » On the 1999 YRBS, forced sex was reported by 9% of respondents (8% of 9th graders and 10% of 11th graders). The majority were female (13% vs. 5% of males).

Forced sex is associated with early onset of sexual activity. According to the CDC, nearly 75% of adolescent girls who have had sexual intercourse before age 14 and 60% of those who had intercourse before age 15 reportedly had experienced involuntary intercourse.³⁰ Forced sexual intercourse has been associated with suicidal ideation

23 Nordstroem, P. et al. (1995).
American Psychological Association (2000).

24 Suokas and Loennquist (1991).

25 National Household Survey on Drug Abuse U.S. Department of Health and Human Services (2000).

26 Males, M. A. (1999), p. 235.

27 National Center for Health Statistics (1996).

28 This item is also asked in the Sexual Behavior Module F, Question HS-19 & MS-14

29 Avery-Leaf et al (1997).

Davis et al (1993).

30 Alan Guttmacher Institute (1994).

and suicide attempts, alcohol and drug use, and increased risk of chronic diseases and somatic symptoms in both reproductive and non-reproductive organ systems.³¹

Data Analysis Suggestion. How is the experience of being forced into having sex related to variations in the other risk behaviors covered in the Core and AOD, Violence, and Suicide Modules, such as eating disorders, drug and alcohol use, and suicidal thoughts?

31 Hartman & Burgess (1993).
Erickson & Rapkin (1991).
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Tables

INDEX OF ITEM AND TABLE NUMBERS—ALCOHOL & OTHER DRUG MODULE

High School Item	Middle School Item	Variable	Report Table
C1	C1	Alcohol use, past 6 months	C1
C2	C2	Marijuana use, past 6 months	C2
C3	C3	Inhalant use, past 6 months	C3
C4	—	Cocaine, meth, or other stimulant use, past 6 months	C4
C5-6	—	Pyschedelics, ecstasy, or other club drugs use, past 6 months	C5
C7	C4	Any other drug use, past 6 months	C6
C8	—	Poly drug use, past 6 months	C7
C9	—	Illegally used steroids, past 12 months	C8
C10	—	Illegally used performance enhancing supplements, past 12 months	C9
C11	—	Frequency of alcohol cessation attempts	C10
C12	—	Frequency of marijuana cessation attempts	C11
C13	—	Perceived need for counseling/treatment for alcohol/drugs use	C12
C14		Likelihood of finding help a school for ATOD use at school	C15
C16	—	Source for obtaining alcohol	C13
C15		Likelihood of suspension/expelled/transferred for ATOD use at school	C14
C19		Occurrence of selling drugs to someone, past 12 months	C16
C20	C7	Occurrence of physical fight, past 12 months	C17
C21	C8	Occurrence of physical fight between groups, past 12 months	C18
C22	C9	Occurrence of weapons use to intimidate, past 12 months	C19
C29	C6	Gambling, past 12 months	C20
C17	C5	Type of gambling, past 12 months	C21
C23	C10	Perceived safety of neighborhood	C22
C24	C11	School days missed due to feeling unsafe, past 30 days	C23
C27	C14	Weapons possession on school property, past 30 days	C24

High School Item	Middle School Item	Variable	Report Table
C25-26	C12-13	Carry gun or other weapon, past 30 days	C25
C28	C15	Seriously consider suicide, past 12 months	C27
C29	C16	Planned method of suicide, past 12 months	C28
C30	-	Attempted suicide, past 12 months	C29
C31	-	Suicide attempt that required medical treatment, past 12 months	C30
-	C17	Ever tried to kill self	C31
C32	C18	Forced sexual intercourse	C26

INDEX OF ITEM AND TABLE NUMBERS—CORE MODULE

High School Item	Middle School Item	Variable	Report Table
—	A75	How many days left alone after school during normal week	A2.7
A24-33	A24-28	AOD use, lifetime	A3.1
A39	A34	Alcohol use frequency, current	A3.2-3.3
A41-45	A36-37	Use of marijuana and other drugs, current (past 30 days)	A3.2-3.3
A34	A29	Drunk or sick after drinking alcohol, lifetime	A3.4
A35	A30	High from using drugs, lifetime	A3.5
A40	A35	Consumption five drinks in a row, current	A3.6
A49	A41	Drinking style or preference	A3.7
A61	—	Drinking and driving experiences (by respondent or other)	A3.8
—	A53	Lifetime, ridden in car by someone who has been drinking	A3.9
A47-48	A39-40	Alcohol/marijuana use on school property, current (past 30 days)	A3.10
A36	A31	High at school on alcohol or other drugs, lifetime	A3.11
A51	A43	Perceived harm of frequent alcohol use	A3.12
A52	A44	Perceived harm of frequent marijuana use	A3.12
A59-60	A51-52	Peer disapproval of using alcohol and marijuana	A3.13
A57	A49	Perception of percentage of peers who ever tried marijuana	A3.14
A54-55	A46-47	Perceived difficulty to obtain alcohol and marijuana	A3.15
A69	A61	Offered, sold, or given an illegal drug on school property, past year	A3.16
A21-22	A21-22	Cigarette smoking, puff or whole, lifetime	A4.1
A23	A23	Smokeless tobacco use, lifetime	A4.1
A37-38	A32-33	Tobacco use frequency, current	A4.2
A46	A38	Smoking on school property, current (past 30 days)	A4.3
A58	A50	Peer disapproval of using cigarettes	A4.4
A50	A42	Perceived harm of frequent cigarette smoking	A4.5
A53	A45	Perceived difficulty to obtain cigarettes	A4.6
A56	A48	Perception of percentage of peers who smoke at least once a month	A4.7

High School Item	Middle School Item	Variable	Report Table
A65	A57	Had mean rumors or lies spread about student at school, past year	A5.1
A66	A58	Had sexual jokes, comments, gestures made at school, past year	A5.1
A67	A59	Made fun of because of looks or the way talks at school, past year	A5.1
A62	A54	Been pushed, shoved, slapped etc., past year	A5.2
A63	A55	Been afraid of being beaten up at school, past year	A5.2
A64	A56	Physical fighting at school, past year	A5.2
A68	A60	Personal property theft and damage on school property, past year	A5.3
A70	A62	Damaged school property on purpose, past year	A5.3
A71	A63	Carried a gun at school, past year	A5.4
A72	A64	Carried any other weapon at school, past year	A5.4
A73	A65	Threatened/injured at school with weapon, past year	A5.5
A74	A66	Seen someone carrying weapon at school, past year	A5.5
A81	A73	Peer disapproval of weapon possession at school	A5.6
A75-80	A67-72	Reasons for harassment on school property, past year	A5.7
A83	A76	Gang involvement, lifetime	A5.8
A74	A66	Seen someone carrying weapon at school, past year	A5.5
A81	A73	Peer disapproval of weapon possession at school	A5.6
A75-80	A67-72	Reasons for harassment on school property, past year	A5.7
A83	A76	Gang involvement, lifetime	A5.8
A84	A77	Hit, slapped, or physically hurt on purpose by a boy/girlfriend	A5.9
A82	A74	Perceived safety at school	A5.10

TOBACCO MODULE

Preface

This report provides the detailed results from the district's administration of the California Healthy Kids Survey (CHKS) supplementary Tobacco Module. It is designed to be used in conjunction with the findings on tobacco from the main report on CHKS Core Module. The report is divided into two sections: (a) a discussion of the items by topic; and (b) the results for each item presented by grade in tables. In both sections, users are provided references to questionnaire items by number, as well as the actual item wording. An index at the beginning of the tables refers users from survey item numbers and variables to the table number in which the results are provided. The index also provides references to the relevant Core tables.

Users should also consult CDE's new Getting Results volume (Part II): California Action Guide to Tobacco Use Prevention Education. It provides research-based strategies for program implementation.

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Special thanks are due to Dr. Jennifer Unger (Institute for Health Promotion and Disease Prevention Research, University of Southern California), who helped in the preparation of individual sections of this report, particularly in examining how data might be used. At WestEd, Drs. Barbara Dietsch and William McCarthy were the lead writers of this section.

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SMOKING FREQUENCY AND PATTERNS

Regular Smoking and Number of Cigarettes Smoked Per Day

Question D1: Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?

Question D3: During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?

Question D4: Have you smoked 100 cigarettes in your life?

Table D1 provides the number of cigarettes students smoked per day, on the days they smoked, in the past 30 days. These data give an indication of how much cigarette users consume on the days that they choose to smoke.

Table D2 reports the proportion of respondents who ever smoked daily, defined as at least one cigarette every day for 30 days. Comparing these results with the proportion of current regular smokers in Table A4.3 provides an indication of the proportion of smokers who may have succeeded in stopping smoking, or at least reducing use from a daily habit.

Table D3 reports the proportion of respondents who smoked 100 cigarettes in their life. This item is an indication of established smoking amongst youth.³²

Cigars

Question D6: During the past 30 days, on how many days did you smoke any cigars, cigarillos or little cigars?

Table D4 reports the rate of any current (past 30 days) smoking of cigars, cigarillos or little cigars. Cigars recently have become popular among young adults and teenagers.³³ In the mid- to late-1990s, cigar bars and lounges began to appear and several prominent actors were photographed smoking cigars. Cigar smoking appeared to be trendy and associated with wealth and enjoyment of life. Many people believe that cigars are less dangerous than cigarettes; they think that the tobacco in cigars is more pure or natural; and they believe that cigar smokers inhale less than cigarette smokers do. However, studies have shown that cigar smoking is associated with an increased risk of cancer, just like cigarette smoking.³⁴

Smoking to Control Weight

Question D2: Did you ever smoke to control your weight?

Why youth say they smoke is important to know when developing intervention programs. The proportion of students reporting that they ever smoked to control their weight is found in Table D5. Weight control is an important issue for young females in particular. Information about smoking and weight control should be included in prevention and cessation classes. The social influences model encourages students to discuss the reasons they smoke or why they think their peers smoke. Table D7 further provides the percent of students who believe smoking helps control weight.

³² Choi et al. (1997).

³³ Centers for Disease Control. (1997).

³⁴ Wald, N. J., & Watt, H. C. (1997).

ATTITUDES AND OPINIONS

Intentions to Smoke

Question D15: How likely do you think it is that you will smoke one or more cigarettes in the next year?

Table D6 provides the proportion of respondents who indicated a likelihood that they might smoke within the next year. In determining program needs, it is important to take into consideration not only the proportion of students who report that they smoke, but also the proportion who indicate future intent to smoke. This is one of the most powerful predictors of smoking.³⁵ Students who acknowledge any possibility of future intent to smoke should be considered at increased risk of smoking compared to those who say “I am sure it won’t happen.” If students have not made a firm commitment not to smoke in the future, encourage them to do so and to make their commitment formal by putting it in writing or stating it in front of their classmates.

Reasons to Use/Not Use

Questions D17-24: Please indicate whether or not you agree with the following statements: Smoking makes kids look grown up...Smoking makes your teeth yellow...Smoking is cool...Smoking makes you smell bad...Smoking helps you make friends...Smoking is bad for your health...Smoking helps you relax...Smoking helps control your weight.

Respondents were given eight statements about smoking and asked to indicate how much they agreed or disagreed with each. Table D7 provides the proportion of students who reported that they agreed or very much agreed with each statement. The statements include both positive reasons for use (e.g., “Smoking is cool”) and adverse effects that might deter use (“Smoking makes your teeth yellow”). These are reasons why teens say they smoke and consequences that are typically discussed in smoking prevention programs. As such, this item is useful in helping assess the effectiveness of tobacco curriculum on youth attitudes. The adverse consequences that seem to be the most powerful in influencing nonsmoking are those most immediately relevant to youth, such as those that affect appearance and social relationships, rather than those related to long-term health.³⁶

The proportion of youth that agreed that smoking is bad for health or dangerous can be compared with the proportion that perceived smoking as harmful in Table A4.6 in the main report.

PEER AND ADULT NORMS

Peer Attitudes and Behavior

Adolescents tend to overestimate the actual prevalence of smoking among their peers. For example, in the 1996 Independent Evaluation of the California Tobacco Control, Prevention, and Education Program, only 17% of the 8th graders reported smoking in the past month, but the 8th graders estimated that 43% of their peers smoked. Similarly, only 27% of the 10th-grade students reported smoking in the past month, whereas 10th graders estimated that 51% of their 10th-grade peers smoked.³⁷

Because of the overestimation of peer substance use, students may smoke in an effort to imitate these peers, when in reality most of the peers are not smokers. Therefore, prevention programs focusing on normative expectations

³⁵ For example, Kaplan et al. (2001).

³⁶ Hurd et al. (1980).

³⁷ Independent Evaluation Consortium. (1998).

designed to counter these misperceptions have been found to be an effective prevention strategy.^{38,39} If local youth are significantly overestimating peer smoking behavior, use the CHKS results to counter this. You can monitor the effectiveness of this strategy by follow-up administrations of the survey to determine if student estimates of peer smoking become more realistic over time, as would be expected. Theoretically, this should be accompanied by a reduction in overall smoking rates.

Adult Smoking

Question D16: About how many adults you know smoke cigarettes?

In Table D8, youth estimates of the proportion of adults they know who smoke at least once a month are presented (none, some, many, most, or all). Adult behavior provides a model for youth. The results for this item can be used in parent education efforts to demonstrate how students' perception of adult use might influence their decisions to use or not to use. (If the supplementary AOD, Violence, and Suicide Module was also administered, these findings can be compared with their estimates of adult use of marijuana.)

ACCESS TO CIGARETTES

Question D5: If you smoked cigarettes during the past 30 days, how did you usually get them?

The Core module asks students to identify how easy it is to obtain cigarettes (see Table A4.7). To shed further light on cigarette availability, Table D9 provides data on where students obtain cigarettes.

Recent laws have attempted to make it more difficult for underage youth to obtain cigarettes. Store employees are instructed to ask people for proof of age when they attempt to purchase cigarettes. Many stores keep their cigarette displays locked so adolescents cannot steal cigarettes. Cigarette vending machines have been removed from many places where adolescents could access them. However, these policies are effective only if enforced.⁴⁰ It is important to determine whether these policies have indeed made it more difficult for adolescents to obtain cigarettes from retail sources.

What percent of students reported purchasing cigarettes from retail sources and were not asked to show proof of age? The 2001 YRBS reported that 19% of the high school students who had smoked in the past month had purchased cigarettes at a store or gas station in the past month. Among the underage students who had purchased cigarettes at a store or gas station, 67% reported that they were not asked to show proof of age.⁴¹ If students are getting cigarettes from retail sources, policies restricting youth access are not being enforced.

What percent of students reported stealing cigarettes from people or stores? What percent of students reported getting their cigarettes from friends or family members? If they are getting cigarettes from social sources, older relatives and friends may need to be educated about the importance of not giving cigarettes to minors. Now that it is more difficult for adolescents to obtain cigarettes from retail sources, some researchers have speculated that they may rely more heavily on social sources (friends and relatives) or illegal channels to obtain their cigarettes.

38 Hansen, W. B., & Graham, J. W. (1991).

39 Flay, Petraitis, & Hu. (1999).

40 Jones et al. (2002).

41 Grunbaum et al. (2002).

SMOKING CESSATION

Question D7: If you now smoke cigarettes, would you like to quit smoking?

Question D8: How many times have you tried to quit smoking cigarettes?

Question D9-11: If you used tobacco during the past 12 months, did you do any of the following things at school to get help to quit using? ...go to a special group or class? ...talk to an adult at your school about how to quit? ...talk to a peer helper about how to quit?

The CHKS asks youth five cessation-related questions: whether they desired to quit, the frequency of cessation attempts, and whether they ever sought help to quit at the school from an adult or peer helper or from a special group or class. Providing encouragement and support for youth cessation efforts is extremely important, because the process of quitting smoking is extremely difficult.⁴² People who try to quit smoking often have intense negative physical and psychological reactions that make them extremely likely to relapse. They typically attempt to quit smoking several times before they quit successfully.⁴³ In this process, they typically progress through stages of change, of which five have been identified:

- » not wanting to quit,
- » contemplating it,
- » taking action,
- » a risk relapse stage, and
- » finally, a maintenance stage in which the smoker has abstained from smoking for a long period of time, such as six months, and has a high probability of success.

This Transtheoretical Model of Change (TMC), also referred to as the Stages of Change Theory, maintains that the way to help people quit smoking is to develop programs that address the participant's readiness to change. Unlike some stage models, it recognizes that subjects can move back and forth between stages or recycle several times through the stages. Unfortunately, a major controlled scientific trial failed to support the utility of the Stages of Change Theory for increasing effectiveness of tobacco control efforts targeted to British school children.⁴⁴ However, that is not to say that programs using this approach should not be included in your district's cessation efforts.

Table D10 provides the proportion of students who have a desire to quit. If only a few smokers express a desire to quit, then efforts may need to be focused on demonstrating why they should stop. If a large proportion wish to quit, it may be a good idea to establish a school-based smoking cessation clinic or class, or at least a referral process for referral to a community-based program. This is particularly important if a high proportion indicate a desire to quit but relatively few have ever tried, as indicated in Table D11. Students may be more likely to quit successfully if they have support from other students who wish to quit, school staff, and trained health educators.

⁴² Fiore et al. (1990).

⁴³ Pallonen et al. (1998).

⁴⁴ Aveyard et al. (1999).

Table D11 reports the frequency that smokers have attempted to quit smoking. The CSS has shown consistently that just under half of the 9th- and 11th-grade smokers (40% and 48% respectively) try to stop the habit at least once. This is a higher cessation-attempt rate than found for illicit drugs and over twice as high as found for alcohol.

Table D12 reports the proportion of students who ever went to a special group or class at school or who ever talked with an adult or peer helper at school about quitting. If these services are available but students are not using them, greater outreach efforts are clearly needed. Consideration should be given to assessing the adequacy of the school TUPE program in promoting the benefits of quitting. This is particularly important if students express a high desire to quit and/or frequency of quit attempts.

PREVENTION PROGRAM EXPOSURE

The Tobacco Module has been designed especially with the needs of TUPE program development in mind. Table D7 reports student agreement with eight statements about smoking and its effects that are typically covered by prevention curricula. Tables D13 through D15 below help assess exposure to any tobacco lessons and to refusal skills training, one of the most common tobacco education strategies.

Exposure to Any Lessons

Question D13: During the past 12 months, did you do any of these things at school? ...have lessons about tobacco and its effects on the body?

The CHKS asks respondents about whether they had any lessons in school about tobacco and its effects on the body in the past year. The results are reported in Table D13. If a high proportion report “yes,” you might compare the curriculum content with the strategies assessed by other items in the survey—such as adverse consequences, refusal skills, and normative education—to determine how well the intended messages have been learned. If a high proportion of students say “no” or “don’t know,” the adequacy of current prevention efforts needs to be examined.

Refusal Skills Training (Self-Efficacy)

Question D12: How hard would it be for you to refuse or say “no” to a friend who offered you a cigarette to smoke?

Question D14: During the past 12 months, did you do any of these things at school? ...practice different ways to refuse or say “no” to tobacco offers?

In Tables D14 and D15 students report on whether they had any practice saying “no” to tobacco offers in the past year and on their ability to refuse a friend’s offer of a cigarette to smoke. Confidence in one’s ability to perform an action successfully is called self-efficacy. People tend to perform the actions that they think they can perform well, and they tend to avoid actions that they think they are unable to perform.⁴⁵ Some students are not confident that they could successfully resist a cigarette offer from a peer; they may not even try to say “no.”

It is not easy for students to tell their friends that they do not want to engage in behavior that their friends think is acceptable.⁴⁶ Prevention research has shown that it is not enough to just tell youth to “just say no.” Self-efficacy develops through successful performance of the behavior. They need to engage in role-playing and practice. These skills must be reinforced with regular booster sessions and practiced each year until students feel confident in their

⁴⁵ Bandura, A. (1986).

⁴⁶ Friedman, Lichtenstein, & Biglan. (1985).

ability to refuse tobacco. Students who have practiced saying “no” and have been successful will have increased confidence and be more likely to say “no” in the future.

Most tobacco prevention curricula that have shown effectiveness incorporate refusal skills training.⁴⁷ Typically students do role-plays in which one student offers a cigarette and another student practices saying “no.” If the student says “no” assertively and firmly, compliment the student. If the student seems uncertain, brainstorm ways that the student can say “no” more assertively, without being bullied, ridiculed, or pressured into trying the cigarette. Of course, students will say “no” to a cigarette offer only if they truly do not want to smoke. Therefore, it is not enough to teach students how to say “no.” Students must be convinced that smoking is not attractive or cool.

If respondents report that they haven’t received any resistance training in the past year, or students have had training but report little confidence in refusal skills, the value of current anti-tobacco curricula needs to be assessed.⁴⁸ Even if the curriculum being used does have regular refusal skills training, the teachers may not be implementing the program appropriately.⁴⁹

You might want to further analyze your results to determine if the percentage of students who feel that they would be unable to say “no” differs by grade level, gender, or ethnicity. Some researchers have speculated that adolescents from certain cultural backgrounds (such as Asian Americans or Hispanic/Latinos) may have difficulty saying “no” because their cultural norms and values emphasize harmonious relationships with other people.

Research also suggests that the assertiveness skills and negotiation skills used to refuse cigarette offers are also useful in helping adolescents to avoid other undesirable behaviors, such as drug use, unsafe sex, fighting, and gangs.⁵⁰ Thus if students report lacking these skills it may be a good idea to implement a school-wide generic program to teach assertiveness skills, conflict resolution skills, and negotiation skills.

47 Ellickson & Hays. (1990).

48 Centers for Disease Control. (1994). Guidelines for school health programs to prevent tobacco use and addiction.

49 Botvin et al. (1990).

50 Charlton, Minagawa, & While. (1999).

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INDEX OF ITEM AND TABLE NUMBERS—TOBACCO MODULE

High/Middle School Item	Variable	Report Table
D1	Ever smoked daily	D2
D2	Ever smoke to control weight	D5
D3	Number of cigarettes smoked per day, past 30 days	D1
D4	Smoked 100 cigarettes, lifetime	D3
D5	Sources for obtaining cigarettes	D9
D6	Current cigar smoking, past 30 days	D4
D7	Current desire to quit smoking cigarettes	D10
D8	Lifetime frequency of smoking cessation attempts	D11
D9	Go to special group to quit, past 12 months	D12
D10	Talk to adult about how to quit, past 12 months	D12
D11	Talk to peer helper about how to quit, past 12 months	D12
D12	Perceived ability to refuse friend's offer of cigarettes	D15
D13	Tobacco education in school, past 12 months	D13
D14	Refusal skills training in school, past 12 months	D14
D15	Likelihood of smoking in the next year	D6
D16	Estimated prevalence of adult cigarette smoking, monthly	D8
D17	Attitudes toward smoking, grown-up	D7
D18	Attitudes toward smoking, teeth yellow	D7
D19	Attitudes toward smoking, cool	D7
D20	Attitudes toward smoking, smell bad	D7
D21	Attitudes toward smoking, make friends	D7
D22	Attitudes toward smoking, bad for health	D7
D23	Attitudes toward smoking, helps relax	D7
D24	Attitudes toward smoking, control weight	D7

INDEX OF ITEM AND TABLE NUMBERS—CORE MODULE

High School Item	Middle School Item	Variable	Report Table
A21-23	A21-23	Ever tried smoking a cigarette or using smokeless tobacco	A4.1
A43-44	A38-39	Any and daily use of cigarettes and smokeless tobacco, past 30 days	A4.3
A56	A47	Current smoking on school property, past 30 days	A4.4
A69	A59	Peer disapproval of using cigarettes	A4.5
A61	A51	Perceived harm of frequent cigarette smoking	A4.6
A64	A54	Perceived difficulty of obtaining cigarettes	A4.7
A67	A57	Estimated prevalence of peer cigarette smoking at least once a month	A4.8

PHYSICAL HEALTH MODULE

Preface

This report provides the detailed results from the district’s administration of the California Healthy Kids Survey (CHKS) Physical Health & Nutrition Module. It is designed for use in conjunction with the findings on other health behaviors from the main report on CHKS Core Module. The report is divided into two sections: (a) a discussion of the items by topic; and (b) the results for each item presented by grade in tables. In both sections, users are provided references to questionnaire items by number, as well as the actual item wording. An index at the beginning of the tables refers users from survey item numbers and variables to the table number in which the results are provided. The index also provides references to the relevant Core tables.

ACKNOWLEDGEMENTS

The CHKS was developed under contract from the California Department of Education (CDE) by WestEd in collaboration with Duerr Evaluation Resources. Assisting in its development were an Advisory Committee consisting of researchers; education practitioners from county offices of education, school districts, and schools across the state; and representatives from federal and state agencies involved in assessing youth health-related behaviors. Professor Rod Skager served as a special consultant. For more information about the survey, call the toll-free helpline at 888.841.7536, or visit the CHKS website at chks.wested.org.

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Successful health promotion messages emphasize the close link between diet, physical activity, and mental health to school and life success. Young people begin to establish health behaviors in childhood and adolescence. They need to see the relationship between a healthy body and a healthy mind. It is this comprehensive approach, targeting the whole child, which is the goal of health-promotion programs; that is, the ultimate goal is to not just keep youth from negative developmental outcomes such as substance abuse, but to help them to develop robustly and to thrive. Moreover, research indicates that prevention messages targeting drug use and violence are most effective when delivered in the context of an overall healthy-lifestyle approach. Clearly, youth need positive reasons to not use substances.

Schools and youth-serving organizations are in a unique position of not only conveying information about health but also providing opportunities for students to practice health-promoting skills and routines. CHKS information can be used to assist program developers in creating comprehensive health-promotion programs aimed at the specific needs of their school populations. Equally important, the CHKS can be used to educate adults in the school and community about the importance of encouraging and modeling positive eating and exercise habits, particularly given the incidence of obesity in youth nationwide. As behavioral learning theories indicate, we learn from what we observe around us.

Promoting healthy personal habits, providing for enjoyable physical activities, offering good food choices, and addressing depression are just as important to positive youth development and school success as keeping youth safe and drug-free. Students who are hungry, sick, troubled, or depressed cannot function in the classroom, no matter how good the school. Students who eat well and exercise regularly are better able to maintain the energy levels needed for learning and to maintain positive emotional development.

FOOD CONSUMPTION AND NUTRITION CHOICES

It is crucial that schools take the lead in improving the dietary behaviors of youth, in order to increase their potential for learning and good health. Americans currently consume more than 36% of their total calories from fat. High fat diets are associated with increased risk of obesity, heart disease, some types of cancer, type II diabetes, and other chronic conditions. Foods high in vitamins, minerals, complex carbohydrates, and dietary fiber (such as fruits, vegetables and whole grains) are considered more conducive to health. Nutrition and learning are also linked, as noted below.

Because lifetime dietary patterns are established during youth, adolescents should be encouraged to choose nutritious foods and to develop healthy eating habits. Many adolescents have unhealthy eating habits. They often skip meals and, when given a choice, select foods that are fried, high in fat and sugar, and low in nutrients, such as sweet or salty snacks and calorie-dense foods.⁵¹ (Note: dietitians encourage eating more “nutrient-dense” foods such as fruits and vegetables, but discourage eating “calorie-dense” foods such as potato chips and Twinkies.) In a

⁵¹ In one study, more than 84% of young people exceeded national recommendations for total fat intake, and less than 21% ate the recommended five or more daily servings of fruits and vegetables. See: Marx, E. & Wooley, S. F. (Eds.) (1998).

1990 Carnegie Foundation survey, more than half of teachers reported that poor nourishment among students was a problem at their school.⁵²

Links to Achievement. Poor dietary patterns have been shown to significantly affect student achievement by reducing cognitive development and school performance. Well-nourished children learn better, perform higher on standardized test scores, are less apathetic and lethargic, and have better attendance rates at school. Among teenage girls, poor eating habits often result in iron-deficiency anemia, which has been linked to lower scores on a wide range of tests, including developmental scales, intelligence tests, and tasks of specific cognitive function.

Program Implications. Providing an environment in which foods served at school are consistent with what students learn in school about making healthy food choices is an important strategy for health promotion. If students report low rates of fruit and vegetable consumption, examination of the types of foods available at the school may be worthwhile—make sure that healthful snacks are available and that selling high fat and empty calorie snack foods is limited by school policy. The CDC recommends several school-based strategies for improving student eating behaviors in its Guidelines for School Health Programs to Promote Lifelong Healthy Eating (1996).⁵³

Nutritious Food Choices

HS/MS Question E6, 8-9: During the past 24 hours (yesterday), how many times did you... drink 100% fruit juices, such as orange, apple or grape? ... eat fruit?...eat vegetables?

As a measure of dietary practices, the CHKS asks youth how often they drank 100% fruit juice or ate fruits and vegetables in the past seven days. Table E1 displays the percentages of students reporting that they ate foods from each category at least once per day as well as that had at least five servings of any of them. The U.S. Department of Agriculture's Five-a-Day Campaign encourages everyone to eat at least five servings of fruits and vegetables a day.

Milk Consumption

HS/MS Question E4: During the past 24 hours (yesterday), how many times did you drink milk or eat yogurt?

Data on milk consumption is provided in Table E2. Milk is an important source of calcium and other vitamins and minerals important for bone growth. A 1994 study on food intakes found that only 14% of girls and 35% of boys are meeting the 1989 Recommended Dietary Allowance (RDA) for calcium.⁵⁴ Because they are easily absorbed and readily available, dairy products were designated as the preferred source of calcium by the 1994 National Institutes of Health (NIH) Conference on Optimal Calcium Intake.⁵⁵ Failure to meet optimum calcium intake may contribute to childhood fractures and osteoporosis in later life.

Sample ethnicity may affect results. Lactose intolerance is common among Asian and African American adults, which means that they lack the enzyme needed to digest milk. This occurs infrequently in infants and children. However, a family history of lactose intolerance could affect survey results in these populations. If your survey

52 Carnegie Foundation for the Advancement of Teaching (1990).

53 U.S. Department of Health and Human Services. (2000). CDC's Guidelines for School Health Programs: Promoting Lifelong Healthy Eating. Centers for Disease Control and Prevention, February 2000, 1-4. As it emphasizes, through proper nutrition education and services, "schools can help children and adolescents attain full educational potential and good health by providing them with the skills, social support, and environmental reinforcement they need to adopt long-term, healthy eating behaviors."

54 National Center for Health Statistics, Centers for Disease Control and Prevention. Unpublished data from the 1988-94 National Health and Nutrition Examination Survey (May 1998).

55 NIH Consensus Conference Statement: Optimal Calcium Intake, June 6-8, 1994:12(4):3.

results show high proportions of these groups, you may want to look at their consumption of green vegetables as an indicator of calcium intake. A variety of foods such as grains and green leafy vegetables are healthy sources of calcium and can be substituted for milk or other dairy products, if necessary.

Soda and Fried Potatoes

HS/MS Questions E5, E7: During the past 24 hours (yesterday), how many times did you...drink soda pop? ...eat french fries, potato chips, or other fried potatoes?

Tables E3 and E4 report on the consumption of two “undesirable foods”: soda drinking as a gauge of calorie and sugar intake, and eating French fries and other fried potatoes, as a gauge of calorie and total fat intake. If students are drinking large amounts of soda daily, they are most likely substituting soda for the recommended number of servings of milk, thus further compromising calcium, vitamin D, and intake of other important nutrients. French fries and fried potato chips provide extra calories from fat, compared to potatoes that are not fried. These extra calories contribute to overweight and obesity. If a high proportion of students report eating these foods, they may be getting them at school. Again, the importance of schools providing healthful food choices cannot be overemphasized.

PHYSICAL ACTIVITY

HS/MS Questions E1-E3: On how many of the past 7 days did you...exercise or do a physical activity for at least 20 minutes that made you sweat and breathe hard? ...participate in physical activity for at least 30 minutes that did not make you sweat and breathe hard? ...do exercises to strengthen or tone your muscles?

The CHKS asks the frequency with which students engaged in 20 minutes of aerobic exercise, 30 minutes of physical activity, or exercise to strengthen or tone muscles in the past week. Tables E5 and E6 present the proportion of youth who engaged in each activity three or more days per week. The Centers for Disease Control and Prevention recommends that adolescents engage in physical activity (preferably aerobic exercise) that requires movement of the large muscle groups at least three times a week for 20–30 minutes.⁵⁶

Regular physical activity among young people contributes to improved physical, mental, and emotional health, lower rates of risk behavior, and positive academic outcomes. More specifically, exercise has been associated with:

- » increased life expectancy and reduced diseases and disability in later life,
- » maintenance of positive interpersonal relationships,
- » reduced incidence of depression and anxiety,
- » increased use of effective stress management techniques,
- » positive educational outcomes,
- » lower rates of risky disruptive behaviors,
- » reduced fatigue, and
- » improved dietary practices.

56 Centers for Disease Control and Prevention (1996).

Links to Achievement. A healthy body supports a healthy mind. Schools that offer intense physical activity programs have shown positive effects on academic achievement—increased concentration; improved mathematics, reading, and writing test scores; and reduced disruptive behavior—even when the physical education reduces the time for academics.⁵⁷ In one program, when academic class time was reduced by 240 minutes per week to allow for increased physical activity, mathematics test scores were consistently higher than for those not in the program.⁵⁸

Links to Other Risky Behavior. In an analysis of YRBS data, low physical activity among adolescents was associated with cigarette smoking, marijuana use, lower fruit and vegetable consumption, greater television watching, and failure to wear a seat belt.⁵⁹ This supports the notion that youth engaged in positive activities such as physical activity are also less likely to engage in negative health behaviors.

Unfortunately, one half of young people ages 12–21 are not physically active on a regular basis. Physical activity levels in schools have declined along with physical activity levels in general, especially across the high school grades. From 1991 to 1995, the percentage of students who engaged in high school physical education declined from 42% to 25%.⁶⁰

The 2001 Fitness Results for California Students found that nearly half of 5th, 7th, and 9th graders were unable to achieve the minimum fitness standard for aerobic capacity, the major indicator of physical fitness.⁶¹

The YRBS found that 56% of U.S. High School students (79% of 9th graders but only 37% of 12th graders) were enrolled in a physical education class in 1999.⁶²

The American Association for the Child’s Right to Play further estimates that 40% of schools in the United States have either cut recess or are considering doing so.⁶³

Critics of efforts to reduce opportunities for physical activity argue that children are not wired to sit for hours at their desks—they learn best with frequent breaks. Reducing opportunities for physical activity also sends the wrong message when childhood obesity is at epidemic proportions.

BODY MASS INDEX

How tall are you without your shoes on?

How much do you weigh without your shoes on?

57 Symons, C. W. et al. (1997).

58 Shephard, R. J. (1997).

Shephard, R. J. et al. (1984).

Sallis, J. F. et al. (1999).

See also: Nagya, R. (2000).

59 Pate, R. R. et al. (1996). The authors conclude that future studies should examine whether interventions for increasing physical activity in youth can be effective in reducing negative health behaviors.

60 American Medical Association (1994).

61 California Department of Education (2001).

62 Kann, L. et al. (2000).

63 American Association for Child’s Right to Play. URL: <http://www.ipausa.org/recess.htm>.

At the end of the Core module students are asked to indicate their height and weight. These values are used to calculate Body Mass Index, or BMI (wt/ht²) (E7), which is used to determine overweight or underweight specific to gender and age. Obesity has reached epidemic proportions in the United States. In January 2003, CDC reported that obesity climbed from 19.8 percent of American adults to 20.9 percent of American adults between 2000 and 2001.⁶⁴ Overweight children are likely to become overweight adults.⁶⁵ The Centers for Disease Control and Prevention (CDC) has calculated percentile curves that show the pattern of growth for children from ages 2-20 years old. The percentile cutoff point for overweight is BMI-for-age greater than or equal to the 95th percentile. Youth at the 85th percentile are considered to be at risk of overweight. Children who fall into these categories are at increased risk for developing risk factors for cardiovascular disease and diabetes. It is also important to look at the proportion of students who fall below the 5th percentile for BMI as a possible indicator of disordered eating. Schools with high proportions of students with BMI above the 85th percentile may want to consider working with health care providers and food services to determine how the school environment may be contributing to overweight among their students. The CDC growth charts can be found at their website <http://www.cdc.gov/nccdphp/dnpa/bmi/bmi-for-age.htm>.

ATTITUDES, BEHAVIOR, AND PERCEPTIONS ABOUT WEIGHT

Body Weight

HS/MS Question E11: Which of the following are you trying to do about your weight?

HS/MS Questions E12-1E6: During the past 30 days, did you do any of the following things to lose weight or to keep from gaining weight?

HS/MS Question E17: How do you describe your weight?

The rapid growth and development during adolescence increase the demand for total nutrients. These changes also influence the perceptions adolescents have about their bodies. Recent data show that the number of overweight teens is increasing at an alarming rate.⁶⁶

Table E8 provides information about whether students are trying to lose, gain, or maintain body weight, and Table E9 provides information about what students are doing to control body weight. Media messages projecting thinness as the standard for ideal body size further influence body images and often lead to unrealistic expectations of body size, especially among teenage girls. This can lead to lifelong, unhealthy eating behaviors such as caloric restriction, excessive exercise, and the use of pills, powders or other diet remedies. Research suggests that female adolescents who diet at a moderate level are five times more likely to develop an eating disorder than those who do not diet.⁶⁷ The proportion of students who perceive themselves as being over- or underweight are provided in Table E10. Comparing the results from these tables with the proportion of students falling into the overweight or obese categories for body mass index in the Core report will provide information about the accuracy of self perceptions of body weight.

⁶⁴ Mokdad, A. H. et al. (2003).

⁶⁵ Whitaker, R. C. et al. (1998).

⁶⁶ NCHS, Center for Disease Control and Prevention (CDC). (2001, October 31).

⁶⁷ Fischer, M., Golden, N., Katzman, D., Kreipe, R., Rees, J., Schenbendach, J., Sigman, G., Ammerman, S., & Hoberman, H. (1995).

PHYSICAL ACTIVITY

Television Viewing/Playing Video Games

HS/MS Question E18: On an average school day, how many hours do you watch TV or play video games?

Ironically, while large numbers of adolescents are participating in dieting and weight loss behavior, the number of overweight and obese teens is increasing annually. A survey conducted in 1999 estimated that 13% of children aged six to 11 years and 14% of children aged 12 to 19 years are overweight. These estimates indicate that the percentage of adolescents who are overweight has almost tripled in the past two decades.

Citing several obesity-related health problems, such as increased mortality from heart disease and cancer and the increased incidence of Type II diabetes and asthma among children, the Surgeon General's Call to Action⁶⁸ issued in December 2001 outlined five overarching principles to prevent and treat overweight and obesity. To varying degrees, all five of these principles are relevant to health promotion programs in educational settings. Children spend most of their daytime hours at school. Schools provide the ideal setting in which to implement health strategies, beyond health education, in the areas of policy development, improved school environments, and community involvement to help prevent and reduce overweight and obesity among youth.

Table E11 reports the amount of time spent viewing television or playing video games. Increased rates of obesity reflect not only poor food choices, but also a lack of physical activity to utilize excess calories. Participation in regular physical activity helps build and maintain healthy bones and muscles, control weight, and build lean muscle; reduces body fat; reduces feelings of depression and anxiety; and promotes psychological well-being. 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 obesity and violent or aggressive behavior.⁶⁹ If a high proportion of students fall into the overweight or obese categories for body mass index, it may be an indicator that they are spending a lot of time doing sedentary activities.

Physical Activity

HS/MS Question E19: During the past 12 months, on how many sports teams did you play? (Include school sponsored and any other sports teams.)

HS/MS Question E22: In an average week, on how many days do you have physical activity in your physical education class (P.E. or gym)?

HS/MS Question E23: During an average physical education (P.E.) class, how many minutes do you spend actually exercising or playing sports?

Table E12 shows the proportion of students reporting that they participate in sports teams. Although this is not the only indicator of physical activity, it helps assess the degree to which students participate in coordinated sports activities outside of school. Tables E15 and E16 quantify physical activity at schools by asking how many days the students participate in P.E. classes and for how many minutes. When developing comprehensive school health programs planners may want to consider how to engage students in non-sedentary activities that they enjoy and will incorporate into their everyday routine.

⁶⁸ U.S. Department of Health and Human Services. (2001).

⁶⁹ Pearl, D. (1982).

UNINTENTIONAL INJURY

Seat Belt and Bike Helmet Use

HS/MS Question E20: How often do you wear a seat belt when riding in a car driven by someone else?

HS/MS Question E21: When you rode a bicycle during the past 12 months, how often did you wear a helmet?

Even in the era of air bags and antilock brakes, seat belts remain the most effective tool for preventing deaths and injuries from motor vehicle crashes. Motor vehicle crashes are the number one cause of unintentional injury-related deaths for children ages one to 14.⁷⁰ Table E13 provides the proportion of respondents who indicated that they wore seat belts.

In 1997, an estimated 567,000 Americans sustained a bicycle-related injury that required emergency care.⁷¹ Approximately two-thirds of these cyclists were children or adolescents. The single most effective safety device available to reduce head injury and long term disability or death from bicycle crashes is a helmet; nevertheless, many adolescents do not wear helmets. Table E14 shows the proportion of students that report using a helmet while riding a bicycle. Barriers to helmet use include cost, wearability of bicycle helmets, and a lack of knowledge regarding helmet effectiveness. Education on helmet use and laws requiring individuals to wear helmets when riding bicycles are methods to increase usage and prevent injury.

GENERAL HEALTH

Health Examinations

HS/MS Question E24: During the past 12 months, did you have a regular check up with a doctor when you were not sick or injured?

HS/MS Question E25: During the past 12 months, did you visit a dentist for an examination, teeth cleaning, or dental work?

Routine examinations are a critical prevention technique to ensure the health and well-being of youth. Regular visits to the doctor and dentist are important for diagnosing physical problems and are instrumental in discovering indicators of tobacco, drug, and alcohol use, eating disorders, and depression. Tables E17 and E18 provide information about how many students reported seeing a doctor or dentist in the twelve months before the survey. The Society for Adolescent Medicine recommends adolescents have a complete health checkup at least every year, or sooner if needed.

Vitamin Use

HS/MS Question E26: During the past 7 days, how many days did you take a vitamin?

Table E19 shows the proportion of students reporting use of vitamins. This question is an indicator of general awareness of preventive health behavior. The American Dietetic Association and the Society for Adolescent Medicine recommend that youth obtain most of their vitamins and minerals from a variety of foods. Schools provide the optimal venue for students to learn good eating habits.

⁷⁰ U.S. Department of Health and Human Services. (1999).

⁷¹ Insurance Institute for Highway Safety (IIHS). (1997). *Fatality facts: Bicycles*. Arlington, VA: IIHS.

HIV/AIDS Education

HS Question E27: Have you ever been taught about AIDS or HIV infection at school?⁷²

There is much debate and discussion about the roles of schools in relation to the education of pre-adolescents and adolescents about AIDS, sexuality, and risk reduction. The dramatic twofold increase in the number of AIDS cases among older adolescents between 1989 and 1993, the fact that nearly one in five persons with AIDS is age 20-29 (meaning that the disease was likely contracted in adolescence), the reality that the 9th leading cause of death for young people age 15-25 is AIDS, and the fact that as many as 30% of teenage males do not receive any sex education prior to first intercourse clearly justify the need for AIDS prevention education targeted to youths.^{73, 74} Table E20 reports on the number of high school students who received HIV/AIDS education at school.

According to a recent Kaiser Family Foundation study, students want more information about sexual and reproductive health issues than they are receiving in school. Approximately half of students in grades 7-12 reported needing more factual information about HIV/AIDS and other STDs, how to get tested for these diseases, and how to talk to their partner about them; nevertheless, a significant percentage report that these topics are not covered or not covered in sufficient depth in their most recent sex education course.⁷⁵ Sex education – either through schools or parents – can increase students’ understanding of HIV/AIDS while, at the same time, delay age of first intercourse, thus reducing levels of sexual activity and increasing contraceptive or condom use.⁷⁶

ASTHMA

HS /MS Question E10 : Has a doctor ever told you or your parent/guardian that you have asthma ?

HS Question E28/MS Question E27: During the past 12 months, have you had an episode of asthma or an asthma attack?

HS Question E29/MS Question E28: During the past 12 months, have you ever had a cough, chest tightness, trouble breathing, or wheezing that was so bad that you could not finish saying a sentence?

HS Question E30/MS Question E29: During the past 12 months, have you been to the emergency room or stayed overnight in the hospital because of a cough, chest tightness, trouble breathing, or wheezing?

HS Question E31/MS Question E30: During the past 12 months, have you used a medicine (an inhaler, puffer or a breathing machine) to treat a cough, chest tightness, trouble breathing, or wheezing?

HS Question E32/MS Question E31: During the past 30 days, about how many days each week have you had a cough, chest tightness, trouble breathing, or wheezing when you did not have a cold or flu?

HS Question E33/MS Question E32: During the past 30 days, about how many nights did you wake up because of a cough, chest tightness, trouble breathing, or wheezing when you did not have a cold or flu?

Asthma has become a major national public health concern. Between 1980 and 1994, the prevalence of asthma increased 75% overall and 74% among children five to 14 years of age. Asthma accounts for 14 million days of school missed annually and is the third-ranking cause of hospitalization among those younger than 15 years of

72 Indicates that this question was not asked in the Middle School Survey.

73 Levy, S.R., Weeks, K., Handler, A., Per Hata, C., Franck, J.A., Hedeker, D., Zhu, C., Flay, B. R. (1995).

74 Murphy, S. L. (2000).

75 Henry J. Kaiser Foundation. (1998).

76 Lindberg, L.D., Ku, L., & Sonenstein, F. (2000).

age. Asthma can be a life-threatening disease if not properly managed.⁷⁷ It is estimated that 24.7 million have been diagnosed with asthma by a health professional; more than a third of them (at least 7.7 million) are children under 18 years of age. In 1999, 3.8 million (out of the 7.7 million) had an asthmatic episode.⁷⁸ The asthma-related questions in the Physical Health Module provide information on those currently experiencing asthma attacks, specific asthma-related symptoms, asthma management (i.e. health care and medication use), and level of functioning.

Tables E21 through E27 show the results to these asthma-related questions. Students who responded on the Core Module that they do not have a medical diagnosis of asthma may nevertheless answer “yes” to one or more of these questions. A higher proportion of students responding positively to these questions than to the Core asthma question may indicate students who have asthma and have not been diagnosed or whose asthma is not managed properly. In conjunction with the asthma question in the Core Module, this report provides a preliminary description of the prevalence of asthma and asthma-related symptoms among students in your school or district. In addition, combining the responses to these questions allows the estimation of the number of students who may have uncontrolled asthma or who are experiencing asthma-related symptoms so severe it limits their ability to perform in school.

77 Air Pollution and Respiratory Health Branch, National Center for Environmental Health Centers for Disease Control and Prevention.

78 American Lung Association. (2002, March).

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Tables

INDEX OF ITEM AND TABLE NUMBERS—PHYSICAL HEALTH MODULE

High School Item	Middle School Item	Variable	Report Table
E1	E1	Exercise past 7 days...physical activity for at least 20 minutes that made you sweat and breathe hard	E5
E2	E2	Exercise past 7 days... physical activity for at least 30 minutes that did not make you sweat and breathe hard	E5
E3	E3	Exercise past 7 days... strength or tone muscles	E6
E4	E4	Drinking milk and eating yogurt, past 24 hours	E2
E5	E5	Drinking soda pop, past 24 hours	E3
E6	E6	Eating/drinking past 24 hours...100% fruit juice	E1
E8	E8	Eating/drinking past 24 hours...fruit	E1
E9	E9	Eating/drinking past 24 hours...vegetables	E1
E7	E7	Eating fried potatoes past 24 hours	E4
E11	E11	Action on weight... lose; gain; stay same; nothing	E8
E12	E12	Actions to lose/maintain weight, past 30 days, exercise	E9
E13	E13	Actions to lose/maintain weight, past 30 days, intake	E9
E14	E14	Actions to lose/maintain weight, past 30 days, fasting	E9
E15	E15	Actions to lose/maintain weight, past 30 days, diet supplements	E9
E16	E16	Actions to lose/maintain weight, past 30 days, vomit or take laxatives	E9
E17	E17	Perception of your weight	E10
E18	E18	Hours watching TV/playing video games, school day	E11
E19	E19	How many sports teams did you play, past 12 months	E12
E20	E20	Seat belt use riding in car driven by someone else	E13
E21	E21	Helmet use riding bicycle, past 12 months	E14
E22	E22	Days of physical activity in P.E. class, average week	E15

High School Item	Middle School Item	Variable	Report Table
E23	E23	Actual minutes exercising in Physical Education class	E16
E24	E24	Regular medical check-up, past 12 months	E17
E25	E25	Visit dentist, past 12 months	E18
E26	E26	Vitamin use, past 7 days	E19
E27		HIV/AIDS education at school	E20
E10	E10	Diagnosed with asthma	E21
E28	E27	Occurrence of asthma attack, past 12 months	E22
E29	E28	Could not finish sentence due to asthma symptoms, past 12 months	E23
E30	E29	Emergency room/hospital visit due to asthma symptoms, past 12 months	E24
E31	E30	Used medicine to treat asthma symptoms, past 12 months	E25
E32	E31	Days per week that asthma symptoms occur, past 30 days	E26
E33	E32	Nights woken up due to asthma symptoms, past 30 days	E27
		Student body mass index	E7

SEXUAL BEHAVIOR MODULE

This report provides the detailed results from the district’s administration of the California Healthy Kids Survey (CHKS) supplementary Sexual Behavior Module. It was designed to provide data on sexual behavior and practices that lead to HIV/AIDS, sexually transmitted diseases, and pregnancy that are not provided on the Core Module. The report is divided into two sections: (a) a discussion of the items by topic; and (b) the results for each item presented by grade in tables. In both sections, users are provided references to questionnaire items by number, as well as the actual item wording. An index at the beginning of the tables refers users to survey item numbers and variables, and to the table number in which the results are provided.

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PREVALENCE OF SEXUAL INTERCOURSE

HS/MS Question F11: Have you ever had sexual intercourse?

Table F1 presents the proportion of respondents who report ever having sexual intercourse. Nationally, half (50%) of all high school students have had sex during their lifetime, with males (52%) reporting slightly higher rates than females (48%).⁷⁹ At every age, a higher percentage of males than females are sexually experienced. While most teens have not had sexual intercourse by the age of 15 (8 in 10 girls and 7 in 10 boys), the likelihood of having intercourse increases steadily throughout the teen years, with only about one in five individuals remaining virgins by the time they reach age 20.⁸⁰

Trend data indicate that, nationally, the percentage of U.S. high school students who ever had sexual intercourse decreased 16% between 1991 and 2001.⁸¹

Age at First Intercourse

HS/MS Question F12: How old were you when you had sexual intercourse for the first time?

Table F2 provides the age of first sexual intercourse. While teens who do have sex are having sex earlier, particularly for those under the age of 15⁸², most young people don't begin having sex until their mid-to-late teens. Nationwide, 8.3% of students had initiated sexual intercourse before age 13. Overall, male students (12.2%) were significantly more likely than female students (4.4%) to have initiated sexual intercourse before age 13.⁸³

Early sexual activity is associated with unwanted pregnancy and sexually transmitted diseases (STD), including HIV infection, and can have negative effects on social and psychological development. The younger a girl is when she has sex for the first time, the more likely she is to have had unwanted or non-voluntary sex.

Numer of Sexual Partners

HS Question F13: During your life, with how many people have you had sexual intercourse?⁸⁴

*HS Question F14: During the past three months, with how many people did you have sexual intercourse?**

Tables F3 and F4 provide respondents' estimates of the number of sexual partners in their lifetime and in the past three months. Comparing these results with those of Table F1 may provide an indication of the proportion of students who are currently sexually active (had sex in the past three months).

Among sexually experienced teens in 1995, 8 to 10 percent of respondents reported that they had no partners in the previous year, indicating that they were not currently sexually active. The majority of sexually experienced teens had

79 Center for Disease Control and Prevention (CDC). (2000).

80 Singh, S., & Darroch, J. E. (1999).

81 CDC. (2002).

82 DHHS. (1995).

83 CDC. (2002).

84 * indicates that this question was not asked in the Middle School survey.

either 0 or 1 partner in the past year (54% of males and 70% of females). However, 20% of teen males and 13% of teen females had 3 or more partners in the past year.⁸⁵

More recently, 16.2% of all students nationwide reported having sexual intercourse during their lifetime with four or more sex partners. Overall, male students (19.3%) were significantly more likely than female students (13.1%) to have had four or more sex partners.⁸⁶ The percentage of high school students who had multiple sex partners decreased 24% between 1991 and 2001 (CDC, 2002).

Alcohol and Drug Use

*HS Question F15: Did you drink alcohol or use drugs before you had sexual intercourse the last time?**

In addition to the various drug and alcohol use questions in the CHKS Core and AOD, Violence, and Suicide Module, the CHKS asks one question in the sexual behavior module that relates the use of drugs or alcohol to sexual activity (Table F5). Among currently sexually active students nationwide, 24.8% had used alcohol or drugs at last sexual intercourse. Overall, male students (31.2%) were significantly more likely than female students (18.5%) to have used alcohol or drugs at last sexual intercourse.⁸⁷ The percentage of students in grades 9-12 who used alcohol or drugs before the last sexual intercourse increased 18% between 1991 and 2001.⁸⁸

Alcohol and other drug use are linked to risky sexual behavior and pose significant threats to the health of adolescents. Substance abuse may impair adolescents' ability to make judgments about sex and contraception, placing them at increased risk for unplanned pregnancies, sexual assault, or becoming infected with a sexually transmitted disease, including HIV/AIDS.⁸⁹ Studies show that adolescents are less likely to use condoms when having sex after drinking alcohol than when sober.⁹⁰

Contraceptive Use

HS Question F16/MS Question F13: The last time you had sexual intercourse, did you or your partner use a condom?

*HS Question F17: The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?**

Table F6 reports the use of condoms. Among currently sexually active students nationwide, 58% reported that either they or their partner had used a condom during last sexual intercourse. Overall, male students (65.5%) were significantly more likely than female students (50.7%) to report condom use.⁹¹ Among students who are currently sexually active, the prevalence of condom use increased during 1991-1999 and then leveled off by 2001.⁹²

85 Moore, K. A., Driscoll, A. K., & Lindberg, L. D. (1998a).

86 CDC. (2000).

87 CDC. (2000).

88 CDC. (2000).

89 DHHS. (1991).

90 Strunin, L., & Hingson, R. (1992).

91 CDC. (2000).

92 CDC. (2002).

Use of latex condoms by males, when used consistently and correctly, are 98% effective in preventing pregnancy and up to 99.9% effective in reducing the risk of STD transmission.⁹³ Every year, 3 million teens—about 1 in 4 sexually experienced teens—acquire an STD.⁹⁴ In a single act of unprotected sex with an infected partner, a teenage woman has a 1% risk of acquiring HIV, a 30% risk of getting genital herpes, and a 50% chance of contracting gonorrhea.⁹⁵

There has been a dramatic increase in condom use at first sex. Condom use at first sex among teen females nearly tripled, from only 23% in 1982 to 70% in 1995.⁹⁶ Results from the National Survey of Adolescent Males have also shown a dramatic increase in condom use at first sex. In 1988, 55% of sexually experienced males reported using either a condom alone or a condom in conjunction with another method. By 1995, this percentage increased to 69% of sexually experienced males.⁹⁷ Condom use at most recent sex remained fairly stable between 1988 (26%) and 1995 (28%).⁹⁸

Table F7 reports the use of contraceptives to prevent pregnancy. Successful use of contraception requires motivation, consistency, and efficacy; otherwise teens face the likelihood of an unintended pregnancy or contraction of sexually transmitted diseases. A sexually active teenager who does not use contraceptives has a 90% chance of becoming pregnant within one year.⁹⁹

Teenage women's contraceptive use at first intercourse rose from 48% to 65% during the 1980s, almost entirely because of a doubling in condom use. By 1995, contraceptive use at first intercourse reached 78%, with 2/3 of it condom use.¹⁰⁰ About 1 in 6 teenage women practicing contraception combine two methods, primarily the condom and another method.¹⁰¹ The method teenage women most frequently use is the pill (44%), followed by the condom (38%). About 10% rely on the injectable, 4% on withdrawal, and 3% on the implant.¹⁰² Teenagers are less likely than older women to practice contraception without interruption over the course of a year, and more likely to practice contraception sporadically or not at all.¹⁰³ According to the results of the most recent YRBS, among currently sexually active students nationwide, 18.2% reported that either they or their partner had used birth control pills before the last sexual intercourse.¹⁰⁴

Findings on contraceptive use among teens is mixed. While the percentage of teens using contraception the first time they have sex has been steadily increasing since 1982, the percentage of teens using contraception the last time they had sex is declining.¹⁰⁵ National Survey of Family Growth (NSFG) data indicate that the proportion of sexually

93 CDC. (1997).
Kestelman & Trussell. (1991).

94 Alan Guttmacher Institute (AGI). (1994).

95 AGI. (1994).

96 Abma et al. (1997).

97 Sonenstein, F. L., Ku, L., Lindberg, L. D., Turner, C. F., & Pleck, J. H. (1998).

98 Darroch, J. E., & Singh, S. (1999).

99 Harlap, S., Kost, K., & Forrest, J. D. (1991).

100 AGI. (1994).

101 Piccinino, L. J., & Mosher, W. D. (1998).

102 AGI. (1999b).

103 Gleib, D. A. (1999).

104 CDC. (2002).

105 Darroch, J. E., & Singh, S. (1990).

active female teens who used contraception at most recent sex declined from 77% in 1988 to 69% in 1995.¹⁰⁶ In other words, almost one-third (31%) of adolescent females reported no contraceptive use at their most recent sexual intercourse. Between 1988 and 1995, use of oral contraceptives at most recent sex declined dramatically from 42% to 23%. This decline was offset, in part, by use of Norplant and Depo Provera (8% in 1995), which have only been available since the early 1990s.

The overwhelming majority of teens say that it is important for teens to use contraception each and every time they have sex, but research shows that three out of 10 teen girls were completely unprotected the last time they had sex, and between 30 and 38 percent of teens who use contraception use it inconsistently. Pressure from partners not to use contraception is not uncommon. More than half of teens recently surveyed (51.7%) said one of the main reasons that teens do not use contraception is because their partner doesn't want to. Teen boys (49.3%) and girls (54.2%) agree that pressure from their partners is one of the main reasons that teens fail to use birth control.¹⁰⁷

Pregnancy

*HS Question F18: How many times have you been pregnant or gotten someone pregnant?**

Table F8 reports the number of pregnancies. Nationwide, 6.3% of students reported that they had been pregnant or had gotten someone else pregnant.¹⁰⁸ Teen pregnancy and teen births have been steadily declining since the early 1990s - a 17% decline between 1990 and 1996 - from 117 pregnancies per 1,000 women aged 15-19 to 97 per 1,000.¹⁰⁹ Steep decreases in the pregnancy rate among sexually experienced teenagers accounted for most of the drop in the overall teenage pregnancy rate in the early-to-mid 1990s. While 20% of the decline is because of decreased sexual activity, 80% is due to more effective contraceptive practice.¹¹⁰ However, despite these declines, about 40% of American women become pregnant before the age of 20.¹¹¹ The result is nearly 1 million pregnancies each year among teenage women—10% of all women aged 15 to 19 and 19% of those who have had sexual intercourse.¹¹² In 1996, more than half (56%) of the 905,000 teenage pregnancies ended in births (2/3 of which were unplanned), one third (30%) in abortion, and one sixth (14%) in miscarriage.¹¹³

The United States has higher teen pregnancy rates than many other developed countries—twice as high as in England and Wales or Canada, and nine times as high as in the Netherlands or Japan.¹¹⁴

The research clearly shows that many antecedents of teenage childbearing are related to some form of social disadvantage (e.g., poverty, low education, family and residential instability, unemployment and limited career opportunities, membership in a minority group, and sexual or physical abuse).¹¹⁵ Less clear is an understanding

106 Abma, J. C., Chandra, A., Mosher, W. D., Peterson, L. S., & Piccinino, L. J. (1997).

107 The National Campaign to Prevent Teen Pregnancy. (2000).

108 CDC. (2000).

109 AGI. (1999a).

110 AGI. (1999c).

111 The National Campaign to Prevent Teen Pregnancy. (1997).

112 AGI. (1999a).

113 Henshaw, S. K. (1998).

114 AGI. (1994).

115 Kirby, D. (1997).

Miller, B. C. (1995).

of the mechanisms through which these factors result in teenage childbearing. One hypothesis is that social disadvantage and its behavioral sequelae (early sexual initiation, less effective contraceptive use and less reliance on abortion to end unplanned pregnancies) make it difficult for youth to avoid the risks and negative consequences of becoming pregnant and bearing a child.¹¹⁶ An alternative hypothesis is that social disadvantage contributes to attitudes or norms that favor nonmarital teenage childbearing as a rational adaptive strategy.¹¹⁷

Studies of the psychological determinants of teenage pregnancy and childbearing indicate that some adolescents may have even more ambivalence¹¹⁸ or preconscious motivation¹¹⁹ toward childbearing than is detected by national surveys that use a single retrospective question to determine women's pregnancy intentions.¹²⁰

There are many consequences to teen pregnancy, some of which are quite negative. Numerous studies have shown that compared with sexually active young women who avoid pregnancy or who become pregnant and choose abortion, those who become pregnant and choose to bear a child are more likely to come from economically disadvantaged families (83%) than are teens who have abortions (61%) or teens in general (38%). Seven in ten teen mothers complete high school, but they are less likely than women who delay childbearing to go on to college. In part because most teen mothers come from disadvantaged backgrounds, 28% of them are poor while in their 20s and early 30s. One-third of pregnant teens receive inadequate prenatal care; babies born to young mothers are more likely to be low birth-weight, to have childhood health problems, and to be hospitalized more often than those born to older mothers.¹²¹ They also tend to live with only one or neither biological parent, and have been sexually abused or raped. Typically, they also have lower educational and career aspirations and older partners.¹²²

Forced Intercourse

HS Question F19/MS Question F14: Have you ever been forced to have sexual intercourse when you did not want to?

The CHKS asks about experiencing forced sexual intercourse (Table F10). This question is needed to better understand related behaviors such as age of onset of sexual activity, number of sexual partners, use of contraception, and related risk behaviors such as eating disorders, drug and alcohol use, suicidal thoughts, and sexual aggression or sexual victimization.

Moore et al (1995).

116 Trent, K., & Crowder, K. (1997).

Furstenburg, F. F., Jr. (1991).

117 Geronimus, A. T. (1991).

Geronimus, A. T. (1992).

118 Zabin, L. S., Astone, N. M., & Emerson, M. R. (1993).

119 Adler, N. E., & Tschann, J. M. (1993).

120 Frost, J. J., & Oslak, S. (1999).

121 AGI. (1994).

122 Zabin, L. S., Hirsch, M. B., & Boscia, J. A. (1990).

Kenny, J. W., Reinholtz, C., & Angelini, P. J. (1997).

Plotnick, R. D. (1992).

Manlove, J. (1998).

Wu, L. (1996).

Moore, K. A. et al (1998b).

Estimates vary as to the rate of involuntary sex among teen girls based on age and source. The younger the women are when they first have intercourse, the more likely they are to have had unwanted or involuntary first sex. According to the YRBS, nationwide, 7.7% of high school students report having ever been forced to have sexual intercourse when they did not want to. Female students (10.3%) were significantly more likely than male students (5.1%) to have been forced to have sexual intercourse.¹²³

The National Campaign to Prevent Teen Pregnancy estimates that close to four in ten girls who had first intercourse at 13 or 14 had non-voluntary or unwanted sex.¹²⁴ However, the Alan Guttmacher Institute (1994) reports even higher rates. The statistics on sexual abuse, rape, incest, and male predators show that 74% of the women who had intercourse before age 14, and 60% of those who had sex before age 15, report having had sex involuntarily.

Beliefs About the Prevalence of Sexual Intercourse

HS/MS Question F1: About what percent of students in your school grade do you think ever had sexual intercourse?

Table F11 provides respondents' estimates of the percentage of their peers who ever had sexual intercourse. This provides an indication of the percentage of youth they believe to have had sex, which can be compared to actual lifetime rates. Documenting these estimates gives insight to perceived norms that shape students' own behavior choices.

Intentions of Attitudes About Sexual Intercourse

HS/MS Question F10: How likely do you think it is that you will choose to have sexual intercourse one or more times in the next year?

HS/MS Questions F2 and F3: Please indicate whether you agree or not with the following statements.

For teens your age, abstinence (not having sexual intercourse) is a better choice than having sexual intercourse.

For some teens under 18 years old, it is a good decision to have a baby.

An important measure of students' integration of behaviors, experiences, beliefs, and attitudes related to sexual activity is their intention to engage in or abstain from sexual intercourse. To gain insight to projected behavior choices, the CHKS measures student intentions to have intercourse one or more times during the next year (Table F9). Intent to have sexual intercourse is important to ask about because intent is predictive of future behavior. Also, this question is often used when it is not feasible to measure actual behavior.

The CHKS assesses attitudes about abstaining from sexual intercourse and about teen parenting (Tables F12 and F13). Attitudes about abstaining from sexual intercourse and about teenage parenting measure the value placed on delaying sexual activity and parenting.

Close to six in ten teens (58%) say sexual activity for high school-age teens is not acceptable even if precautions are taken against pregnancy and STDs; 93% say it is important that they be given a strong message from society that they should abstain from sex until they are at least out of high school.¹²⁵

123 CDC. (2002).

124 Moore, K. A., & Driscoll, A. (1997).

125 National Campaign to Prevent Teen Pregnancy. (2000).

COMMUNICATION WITH PARENTS AND OTHER ADULTS IN THE FAMILY ABOUT SEXUALITY

HS/MS Question F4-F9: In the past 6 months, have you talked with your parents or other adults in your family about...

- *What your parents think about teenagers having sex?*
- *Your questions about sex?*
- *Reasons why you shouldn't have sex at your age?*
- *How your life would change if you became a father or mother while you're a teenager?*
- *Birth control?*
- *AIDS/HIV and other sexually transmitted diseases?*

The CHKS measures the extent to which youth have opportunities to discuss sexuality issues with their parents or other adults in their family (Table F14). These questions reveal how youth view and use their parents or other adult family members as resources for factual information and moral guidance. Parents rate high among many teens as trustworthy and preferred information sources on birth control. One in two teens say they “trust” their parents most for reliable and complete information about birth control.¹²⁶ Seven of ten teens interviewed said that they were ready to listen to things parents thought they were not ready to hear.¹²⁷ Over two decades of research shows that kids who feel connected to their parents are much more likely to delay sexual initiation, less likely to become pregnant or cause a pregnancy, and more likely to use contraception if they are sexually active. Teenagers who have strong emotional attachments to their parents are much less likely to become sexually active at an early age.¹²⁸

126 Kaiser Family Foundation. (1996).

127 Kaiser Family Foundation. (1996).

128 Blum, R. W., & Rinehart, P. M. (1997).

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Tables

INDEX OF ITEM AND TABLE NUMBERS—SEXUAL BEHAVIOR MODULE

High School Item	Middle School Item	Variable	Report Table
F11	F11	Ever had sexual intercourse	F1
F12	F12	How old were you when you had first sexual intercourse	F2
F13	—	Number of sexual intercourse partners, lifetime	F3
F14	—	Number of sexual intercourse partners, past 3 months	F4
F15	—	Alcohol/drug use before sexual intercourse, last time	F5
F16	F13	Condom use before sexual intercourse, last time	F6
F17	—	Methods of pregnancy prevention during last sexual intercourse	F7
F18	—	Frequency of being or getting someone else pregnant	F8
F10	F10	Likelihood have sexual intercourse one or more times next year	F9
F19	F14	Ever forced into unwanted sexual intercourse	F10
F1	F1	Student perception of peers who have had sexual intercourse	F11
F2	F2	For teens your age, abstinence better choice than having sex	F12
F3	F3	For some teens under 18 years old, good decision to have baby	F13
F4-F9	F4-F9	Talked with parents/other adult in family, past 6 months, about...	F14
F4	F4	- What your parents think about teenagers having sex	F14
F5	F5	- Your questions about sex	F14
F6	F6	- Reasons why you shouldn't have sex at your age	F14
F7	F7	- How your life would change if you became father or mother while a teenager	F14
F8	F8	- Birth control	F14
F9	F9	- AIDS/HIV and other sexually transmitted diseases	F14