

Youth Risk Behavior Surveillance – United States, 2005
Q's and A's for Participating Sites

1. What is the Youth Risk Behavior Surveillance System?

The Youth Risk Behavior Surveillance System implemented by CDC is the only surveillance system to monitor a wide range of priority health risk behaviors among representative samples of youth at the national, state, and local levels. Since the system was implemented in 1991, the number of participating states has increased from 26 to 44 and the number of participating cities has increased from 11 to 23.

2. When will a report on the 2005 data be released?

The 2005 data will be released at noon on June 8th in a tele-briefing for reporters.

3. How will the report be published?

The report will be published in the June 9th *MMWR* Surveillance Summary. The *MMWR* Surveillance Summary can be downloaded from www.cdc.gov/mmwr.

4. What data will be included?

The report includes data from the 2005 National Youth Risk Behavior Survey (YRBS). These data are representative of high school students from all 50 states and the District of Columbia. These data can be used to determine how health risk behaviors change over time among students nationwide. In addition, this report includes data from separate YRBS's conducted in 2005 by education and health agencies in 40 states and 21 cities whose data represent their state or city (weighted data). Data from 4 states and 2 cities with data that represent only the students who took the survey (unweighted data) are not included.

5. What topics will be included?

This report covers injury- and violence-related behaviors (e.g., seat belt use, weapon carrying, physical fighting, attempted suicide), tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, physical activity, overweight, general health status, and asthma.

6. Do students tell the truth when answering the questionnaire?

While a few students probably do not answer the YRBS honestly, we believe most students do tell the truth. Our belief is based on several factors:

- **Psychometric studies** – CDC and non-CDC researchers have conducted a series of psychometric studies examining data quality. One of these studies found that most of the questions have substantial reliability. In other words, students provide the same answers after a two-week interval.
- **Survey environment** – Survey administration procedures are carefully designed to protect the confidentiality of the schools and the anonymity of the students. For example, students sit as far apart as possible, neither survey administrators nor teachers wander around the classroom during survey administration, and students usually have the option to seal their completed questionnaire in a blank envelope.
- **The questionnaire** – is designed to protect anonymity of students. No names or other types of personally identifiable information are ever collected. In addition, skip patterns are not used so all students complete the questionnaire in about the same time.
- **Edit and logic checks** – More than 100 edit checks are conducted on each YRBS questionnaire to remove inconsistent responses. For example, students who report carrying a weapon on school property also must have reported carrying a weapon anywhere, or the responses to both questions are deleted. Only a very small percentage of responses are identified as inconsistent in any survey.
- **Congruence with health outcome trends** – The trends in health risk behaviors tend to mirror the trends in health outcomes. For example, YRBS data from the past decade show that the prevalence of sexual experience is decreasing and the prevalence of condom use among sexually active students is increasing. During this same period, rates of teen pregnancies, teen births, and sexually transmitted diseases among adolescents have decreased.
- **Subgroup differences are logical and constant over time and place** – For example, some behaviors like drug use and sexual experience consistently increase by grade, while others, like physical fighting consistently decrease by grade. Other behaviors vary by gender with males more likely than females to use smokeless tobacco.

7. How will the report be disseminated?

Copies of the Surveillance Summary (along with a brief version of this Q and A document and the press release) will be sent via Fed Ex on Wednesday to all the state health departments, state education agencies, and local education agencies that have data in the report. In addition, all DASH funded partners will receive an email on Thursday morning with a copy of the shortened Q and A document and the press release attached, plus the link to the *MMWR* Surveillance Summary. The Surveillance Summary also will

be sent to all subscribers of the *MMWR* and be made available on the Internet (as is done with all *MMWRs*).

Based on our experience with the 2003 data, we are expecting wide interest in this Surveillance Summary. The 2003 data were released in an *MMWR* surveillance summary in May 2004. Since then we have distributed over 10,000 hard copies of that surveillance summary.

8. How will the YRBS data be used?

The national YRBS data will be used to monitor 15 national health objectives for 2010 and 3 of the 10 Leading Health Indicators. It also will be used to describe trends in health risk behaviors over time and disparities in the prevalence of health risk behaviors by race/ethnicity and sex subgroups.

State and local agencies and nongovernmental organizations use YRBS data to set school health and health promotion goals, support modification of school health curricula or other programs, support new legislation and policies that promote health, and seek funding for new initiatives. For example:

- The Milwaukee Public Schools (MPS) used YRBS data to support adoption of evidence-based curricula in MPS schools, community schools, after-school programs, and alternative settings for school-aged youth.
- The Montana Office of Public Instruction and its partners, including the Montana Department of Public Health and Human Services, the Montana Board of Crime Control, Indian Health Service, Healthy Mothers/Healthy Babies, Montana Department of Transportation, and Blue Cross and Blue Shield of Montana, used YRBS data for program planning and improvement
- In Vermont, YRBS data were used to examine the success of statewide tobacco control programs and promote tobacco prevention programs for youth.
- In Wisconsin, classroom activities designed to teach social norms were developed based on YRBS data.

9. What is the most important finding in this report?

While progress has been made during the past 15 years in decreasing the prevalence of various health risk behaviors, many vary significantly by race/ethnicity, putting some subgroups of youth at unnecessary risk for injury and disease.

For example, African American students are least likely to report tobacco, alcohol, cocaine and other drug use, but most likely to report sexual risk behaviors and sedentary behaviors. White students are least likely to report engaging in physical fighting, sexual risk behaviors, sedentary behaviors, and being overweight, but most likely to report frequent cigarette use, smokeless tobacco use, and episodic heavy drinking. Hispanic students are most likely to report attempted suicide and cocaine, heroin, methamphetamine, and ecstasy use.

10. What is the most encouraging news out of the 2005 YRBS?

The YRBSS also has detected overall improvements over time in risk behaviors related to sexual activity, injuries and violence, and tobacco and alcohol use. For example, from 1991-2005, the percentage of high school students who reported ever having sexual intercourse decreased, while the percentage of sexually active students who used a condom during last sexual intercourse increased. The percentage of student who rarely or never wore a seat belt when riding in a car decreased as did the percentage who rode in a car or other vehicle with a driver who had been drinking alcohol. While current cigarette use increased until 1997, it has since decreased. Similarly, current alcohol use increased until 1999, but has since decreased.

11. What can be done to help reduce the prevalence of health risk behaviors among high school students?

There is no simple solution. Families, schools, community organizations, and youth themselves must work together to help address these problems. We think interventions implemented by these groups should be based on the best behavioral research and best practices available. We need to provide all youth with the skills and support they need to adopt healthy behaviors and maintain them throughout their life.

12. What accounts for variance in rates of risk behaviors across states, cities, or subgroups of students?

Health risk behaviors are determined by a complex interaction of personal, social, cultural, economic, and environmental variables. Consequently, differences in health risk behaviors reflect peer norms, adult practices, media influences, availability of intervention programs, state and local laws and policies, and enforcement practices.

13. What states did not conduct a YRBS in 2005?

California
Louisiana (due to Katrina – scheduled for fall 2005)
Minnesota
Pennsylvania
Virginia
Washington