Youth Risk Behavior Survey

(Public Health Comments 2005)

Prepared by

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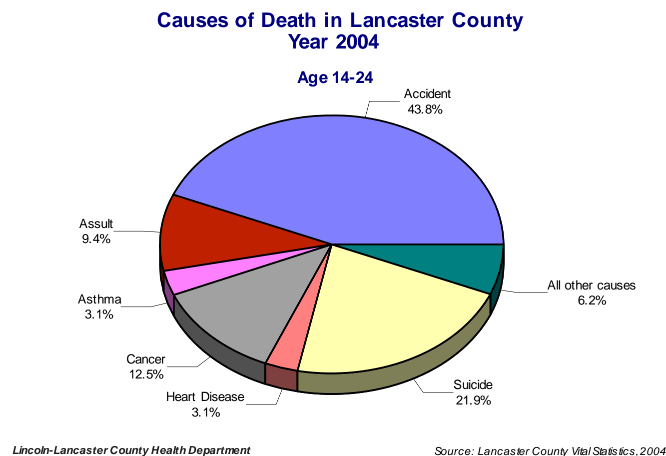
Introduction

Youth Risk Behavior Surveillance: This summary report presents a comprehensive analysis of trends in youth risk behaviors in Lancaster County, as measured by the Youth Risk Behavior Surveillance System (YRBSS) administered in 1991, 1993, 1995, 1997, 1999, 2001, 2003 and 2005. Our report covers five areas of health risk behavior: unintentional and intentional injuries, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, and physical activity.

This summary of comments, and the research data it is based on, was facilitated by the existence of a national Youth Risk Behavior Surveillance System (YRBSS). The national YRBSS was first implemented in 1990 to measure prevalence among young people of behaviors that put their health at risk. The YRBSS is a coordinated system using a standardized survey tool and sampling methods reproduced in the majority of states and many localities across the United States.

Before the establishment of the YRBSS, there was little information on the prevalence of these important risk behaviors among youth in the United States. Yet these areas of risk behavior are arguably the major precursors to death, illness and disability among Americans, not only in their teen years, but also later in adult life. Injuries alone account for the majority of deaths among youth and young adults under 25, in Lancaster County, motor vehicle crashes, other unintentional injuries, assault and suicide accounted for 75.1% of all deaths to those 14 to 24 years of age (see figure below). And although cardiovascular disease and cancer are the major killers of adults, the majority of risk behaviors for these diseases are initiated during adolescence. Unintended teen pregnancy and sexually transmitted disease infection acquired in the teen years cause additional illness and death among youth, young adults, and their children.



The Youth Risk Behavior Survey is an important surveillance, policy, and program management tool for communities, states, and the nation. YRBSS data provide quantifiable evidence of serious health risks among youth which demand public attention and public health action. As such, the data are useful in raising public awareness of the extent of youth risk behaviors. YRBSS data are tools for policy, helping to identify public health priorities and support the need for health education and other prevention efforts for children and youth. The YRBSS is also a tool for prevention and intervention programs -- the data is instrumental in setting program goals and objectives, monitoring the progress and outcomes of public health and other community action, and implementing or modifying public health programs to address the behaviors of young people in priority issue areas.

Data Collection, Analysis: Local data collection was made possible by the cooperation of Nebraska health and education officials coordinating the state YRBSS, as well as the Nebraska YRBSS contractor. The Lincoln-Lancaster County Health Department separately contracted with this contractor to obtain an "over-sample" of the Lancaster County portion of the state survey. This provides the additional sample size needed to obtain valid county-level statistics.

The Youth Risk Behavior Survey measures the prevalence of health-risk behaviors among adolescents through representative national, state, and local surveys conducted biennially. The national and state surveys use multi-stage cluster sampling to obtain samples of students in grades 9-12 reflecting the geographic, urban-rural, racial, gender, and grade makeup of the population in those grade levels. In Lancaster County, the great majority of public schools (urban and rural schools) have participated every survey year, with a high number of schools participating in most years. The survey is conducted in randomly selected classrooms of a required period (second or English period). Parental consent was required beginning in 1997. This disrupted the results to some degree, but has been carefully considered in the analysis of trends. The valid number of surveys has ranged from 739 in 2005 to 1145 in 1999, due to the mix of schools and number of students with parental consent to participate.

Any statements made in this report about Lancaster County youth risk behaviors, whether changes over time or differences between groups, were based on review of statistically significant differences or changes (at a 95% confidence level) and a critical evaluation of consistent data trends. Our goal is to avoid misleading or invalid data comparisons while presenting the maximum in public health data to meet the wide variety of citizen information needs. All statistics presented are "grade-adjusted" numbers (with the exception of data by grade). This was necessary because of large variations from year to year in the proportion of students in each grade that were surveyed. Because there are often substantial behavioral differences between students in younger and older grades, these differences in grade composition of the sample from year to year interfered with valid comparison of behaviors between years or demographic groups. Data were therefore "grade-adjusted" to a common weighted grade distribution (1999 National Public Schools enrollment), so that we are comparing "apples to apples", as it were.

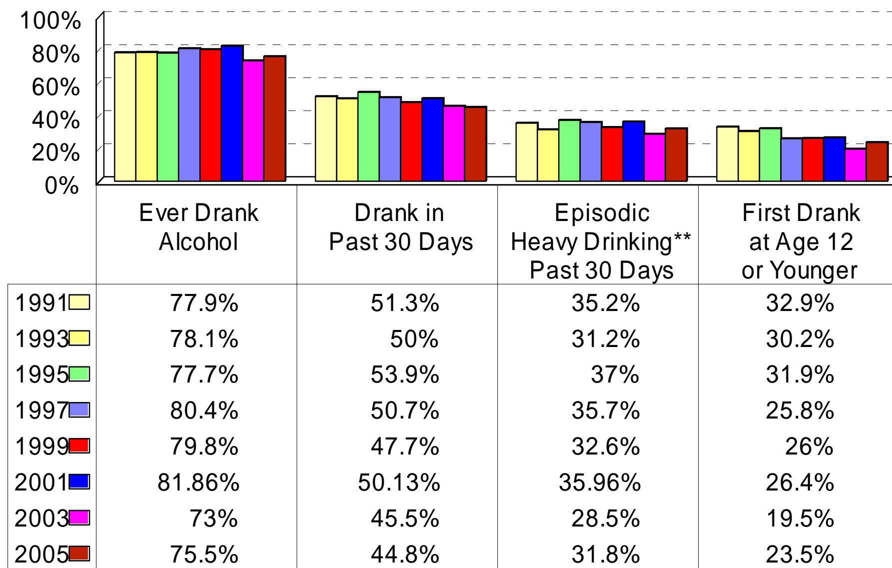
The “grade adjustment” did not affect trend directions, comparisons of males to females or of white to nonwhite students, or overall conclusions from the data. But the procedure did remove bias due to this particular sampling problem, and often helped to smooth out unstable data trends over time.

Public Health Comment: Alcohol

Despite a minimum legal drinking age of 21, many young people make the dangerous choice of consuming alcohol. The consequences of youth alcohol use are far reaching and continue to be a community concern. Many of these harmful consequences are immediate and all too evident including: injuries or death due to impaired driving, violence, sexual assault, unwanted pregnancies, STD's, and educational failure. Young people who decide to drink usually drink more often and more heavily in the 12th grade, but may have started even before the age of 13. In Nebraska 23.9% of the high school students reported in 2005 that they had their first drink of alcohol, other than a few sips, before age 13. This measure is significant because studies show that the longer the onset of first use, the less likely a young person will be affected by an alcohol problem in the future. In Lancaster County we have seen somewhat of a positive trend in this first drink data. In 1995 31.9% of high school students indicated that they had their first drink before the age of 13, while the 2005 survey reveals that 23.5% had their first drink before this age (Figure. 1).

Figure 1: Alcohol Consumption*

High School Students



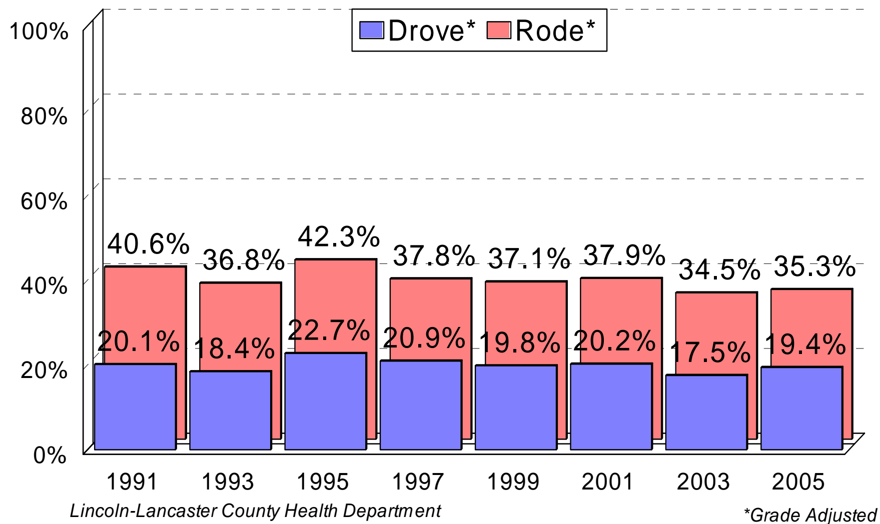
	Ever Drank Alcohol	Drank in Past 30 Days	Episodic Heavy Drinking** Past 30 Days	First Drank at Age 12 or Younger
1991	77.9%	51.3%	35.2%	32.9%
1993	78.1%	50%	31.2%	30.2%
1995	77.7%	53.9%	37%	31.9%
1997	80.4%	50.7%	35.7%	25.8%
1999	79.8%	47.7%	32.6%	26%
2001	81.86%	50.13%	35.96%	26.4%
2003	73%	45.5%	28.5%	19.5%
2005	75.5%	44.8%	31.8%	23.5%

** Five drinks at one sitting

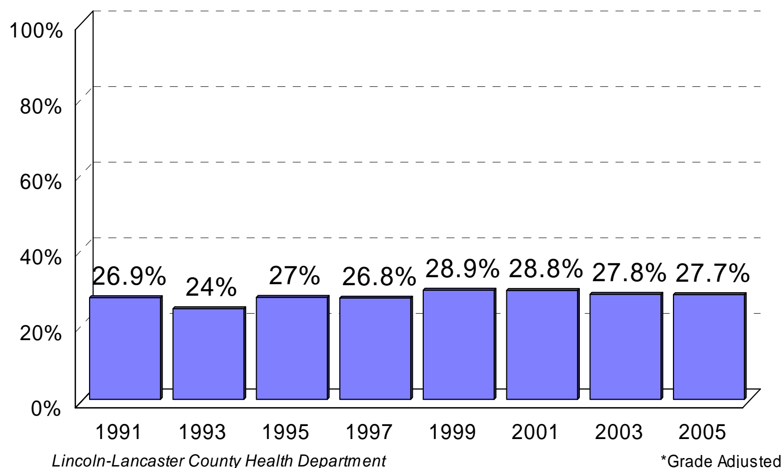
Lincoln-Lancaster County Health Department

*Grade Adjusted

Research shows that high-risk use in Lancaster County includes such issues as: young people drinking and driving or riding with a drinking driver, adults and youth seeing underage drinking as normal and acceptable, and easy access to alcohol (Figure. 2). Measures that have been widely suggested as effective across the county include: strict enforcement of laws prohibiting the use of alcohol by youth, strict regulation of alcohol advertising, educational programs for servers (bartenders, waiters, store clerks, etc), encouragement of alcohol-free youth parties, and a change in community practices that make alcoholic beverages easily accessible to underage youth.



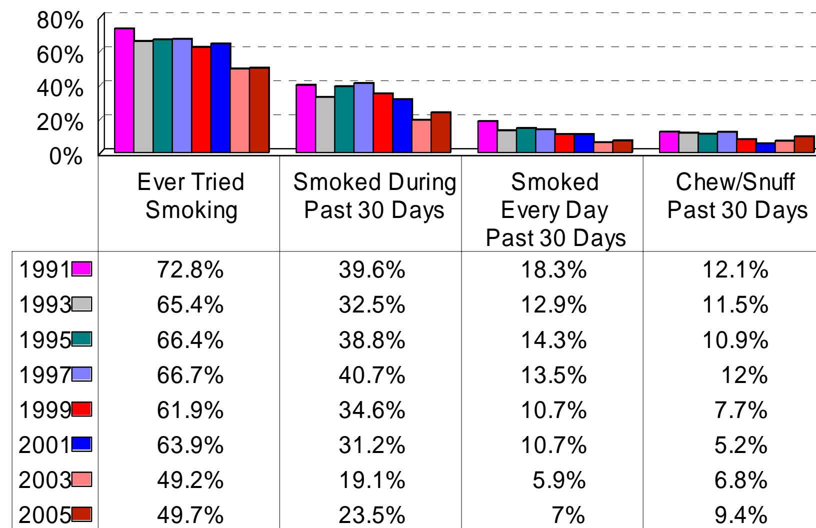
Alcohol abuse among both adults and youth are dangerous problems that must continue to be addressed through on-going prevention efforts that include helping communities recognize that this behavior is not acceptable (Figure. 3). Many organizations in Lancaster County address issues related to alcohol abuse. Among them are Lancaster County Substance Abuse Action Coalition, Lincoln Council on Alcoholism and Drugs, NU Directions, Mothers Against Drunk Driving, Responsible Hospitality Council, Region V Systems, hospitals, treatment centers and self-help programs. With collaborative prevention efforts focused on a comprehensive approach, Lancaster County youth will benefit from making positive choices relating to alcohol use.



Public Health Comment: Tobacco

Every day, more than 3,000 teens become regular smokers in the United States, and about a third of them will die prematurely because of it. Often tobacco addiction is established in early adolescence, resulting in lifelong tobacco use. In 2005, 54.3% of high school students in the U.S. reported having tried cigarette smoking and 23% of high school students reported smoking during the past 30 days. The Nebraska data are similar with 53% of high school students responding that they have tried cigarettes and 22% having smoked in the past 30 days. Tobacco use among youth in Lancaster County has decreased dramatically between 1995 and 2005. In 1995, 66.4% of Lancaster County high school students reported having tried smoking and in 2005 the rate had fallen to 49.7%. In 1995, 38.8% reported smoking during the past 30 days and in 2005 that rate had also dropped to 23.5% (Figure. 4).

Figure 4: Tobacco Use*
High School Students



	Ever Tried Smoking	Smoked During Past 30 Days	Smoked Every Day Past 30 Days	Chew/Snuff Past 30 Days
1991	72.8%	39.6%	18.3%	12.1%
1993	65.4%	32.5%	12.9%	11.5%
1995	66.4%	38.8%	14.3%	10.9%
1997	66.7%	40.7%	13.5%	12%
1999	61.9%	34.6%	10.7%	7.7%
2001	63.9%	31.2%	10.7%	5.2%
2003	49.2%	19.1%	5.9%	6.8%
2005	49.7%	23.5%	7%	9.4%

Lincoln-Lancaster County Health Department **Grade Adjusted*

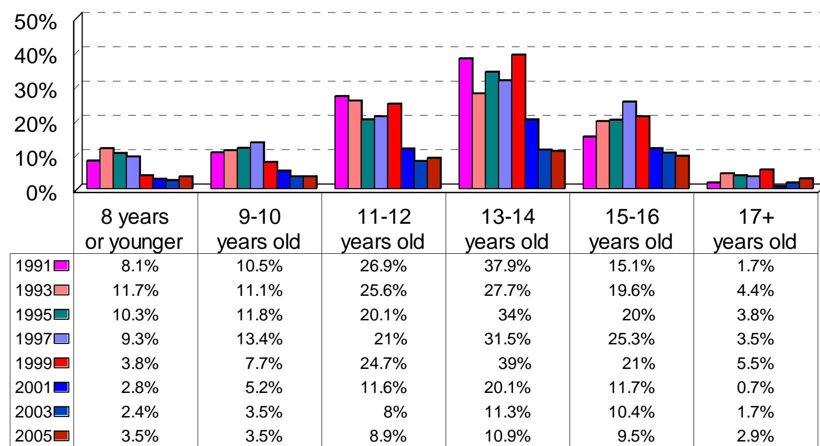
The Centers for Disease Control and Prevention (CDC) recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. These "best practices" are determined by evidence-based analyses of comprehensive state tobacco control programs. The goal of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco by preventing the initiation of tobacco use among young people, promoting quitting among young people and adults, eliminating nonsmokers' exposure to environmental tobacco smoke (ETS) and identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

Through smoke-free programs and state-sponsored anti-tobacco media campaigns, we are changing youth and community attitudes regarding tobacco use. Locally, there is a comprehensive program in place to help prevent youth initiation of tobacco use. The 100% smoke-free policy, known as the Lincoln Smoking Regulation Act, went into effect

in November of 2004 and has been a key component of the comprehensive approach. The School-Community Tobacco Prevention Program in Lincoln and Lancaster County was established in 2000 as part of a comprehensive statewide program. Lincoln and Lancaster County Agencies representing schools, communities, and racial/ethnic minority populations, all part of the Tobacco Free Lincoln Coalition, have a continuing partnership dedicated to reducing public and worker exposure to secondhand smoke and preventing youth initiation of tobacco use. Key elements of this program include involving collaborating agencies working toward goals involving media, enforcement (i.e. illegal tobacco sales to minors), policy and education.

Figure 5: Age at First Use*

High School Students Who Reported Ever Smoking a Whole Cigarette

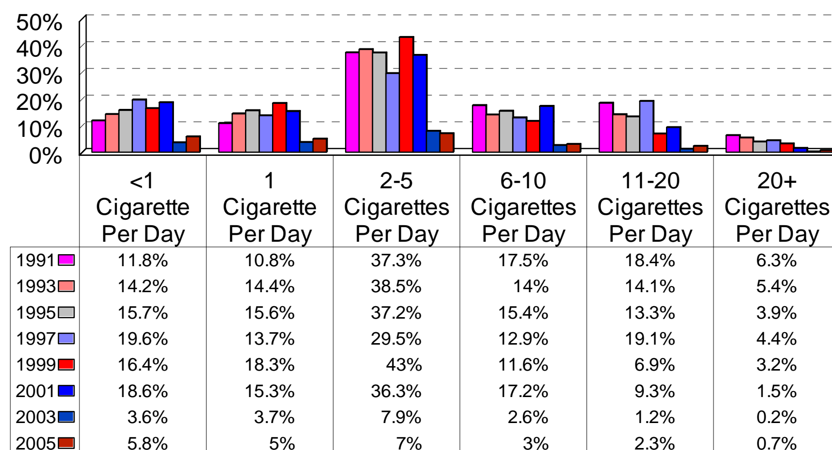


	8 years or younger	9-10 years old	11-12 years old	13-14 years old	15-16 years old	17+ years old
1991	8.1%	10.5%	26.9%	37.9%	15.1%	1.7%
1993	11.7%	11.1%	25.6%	27.7%	19.6%	4.4%
1995	10.3%	11.8%	20.1%	34%	20%	3.8%
1997	9.3%	13.4%	21%	31.5%	25.3%	3.5%
1999	3.8%	7.7%	24.7%	39%	21%	5.5%
2001	2.8%	5.2%	11.6%	20.1%	11.7%	0.7%
2003	2.4%	3.5%	8%	11.3%	10.4%	1.7%
2005	3.5%	3.5%	8.9%	10.9%	9.5%	2.9%

Lincoln-Lancaster County Health Department **Grade Adjusted*

Figure 6: Number of Cigarettes Smoked Per Day*

High School Students Who Reported Smoking During the Past 30 Days



	<1 Cigarette Per Day	1 Cigarette Per Day	2-5 Cigarettes Per Day	6-10 Cigarettes Per Day	11-20 Cigarettes Per Day	20+ Cigarettes Per Day
1991	11.8%	10.8%	37.3%	17.5%	18.4%	6.3%
1993	14.2%	14.4%	38.5%	14%	14.1%	5.4%
1995	15.7%	15.6%	37.2%	15.4%	13.3%	3.9%
1997	19.6%	13.7%	29.5%	12.9%	19.1%	4.4%
1999	16.4%	18.3%	43%	11.6%	6.9%	3.2%
2001	18.6%	15.3%	36.3%	17.2%	9.3%	1.5%
2003	3.6%	3.7%	7.9%	2.6%	1.2%	0.2%
2005	5.8%	5%	7%	3%	2.3%	0.7%

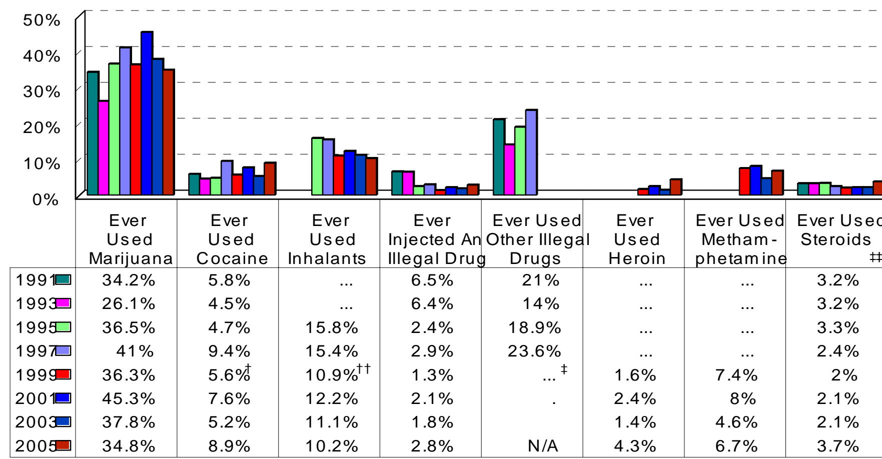
** Number of cigarettes smoked per day, on the days they smoked* *Grade Adjusted*

Lincoln-Lancaster County Health Department

Public Health Comment: Illegal Drugs

Marijuana continues to be the most used illegal drug in America and this holds true in Lancaster County as well. In 2005, 34.8% (Figure. 7) of high school students surveyed reported having used marijuana in their lifetime. In addition, recent risk protective factor surveys administered in Lancaster County point to a decline over the past five years in the percent of the population who perceive that marijuana is a harmful drug. This may be due to an increase in pro-drug messages through pop culture and a lack of awareness among parents.

Figure 7: Lifetime Drug Use*
High School Students



Year	Ever Used Marijuana	Ever Used Cocaine	Ever Used Inhalants	Ever Injected An Illegal Drug	Ever Used Other Illegal Drugs	Ever Used Heroin	Ever Used Metham-phetamine	Ever Used Steroids ‡‡
1991	34.2%	5.8%	...	6.5%	21%	...	...	3.2%
1993	26.1%	4.5%	...	6.4%	14%	...	...	3.2%
1995	36.5%	4.7%	15.8%	2.4%	18.9%	...	...	3.3%
1997	41%	9.4%	15.4%	2.9%	23.6%	...	...	2.4%
1999	36.3%	5.6%†	10.9%††	1.3%	... ‡	1.6%	7.4%	2%
2001	45.3%	7.6%	12.2%	2.1%	.	2.4%	8%	2.1%
2003	37.8%	5.2%	11.1%	1.8%		1.4%	4.6%	2.1%
2005	34.8%	8.9%	10.2%	2.8%	N/A	4.3%	6.7%	3.7%

† "any form of cocaine including powder, crack or freebase" ‡ "LSD, PCP, ecstasy, mushrooms, speed, ice, or heroin"
†† "sniffed glue, breathed the contents of aerosol spray cans, or inhaled paints or sprays" ‡‡ "steroid pills or shots without a doctor's prescription"

Lincoln-Lancaster County Health Department

* Grade Adjusted

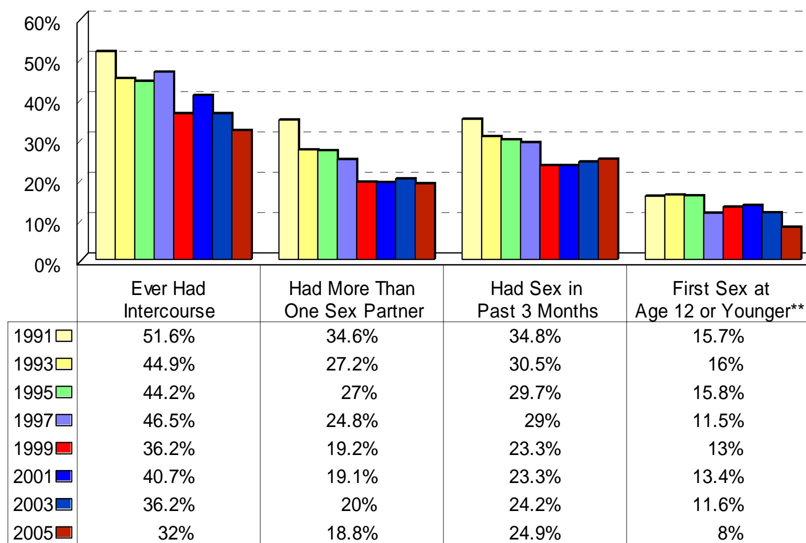
Research has shown that the key risk periods for drug abuse are during major transitions in children's lives. One of the most crucial transitions is when adolescents enter high school where they face more intense social, emotional, and educational challenges. At this same time, they may be exposed to greater availability of drugs, drug abusers, and social activities involving drugs. These challenges can increase the risk that teens will abuse illegal drugs. Prevention programs may vary widely, but generally they are associated with information and referral, education, alternative behaviors, and primary and early intervention activities. These services focus on reducing risk factors and building protective factors.

The Substance Abuse Action Team (SAAT) Prevention Coalition was formed in August 2001 to focus on substance abuse issues in Lincoln and Lancaster County. The coalition's mission is to reduce substance abuse among youth in ages 12 to 17 and to strengthen the coalition into a broad-based, ethnically diverse group of stakeholders dedicated to the principle of making Lincoln and Lancaster County a drug-free community. The coalition is actively recruiting new members, strengthening partnerships with diverse organizations, and planning to provide prevention training for members and the community.

Public Health Comment: Sexual Activity

The care and protection of children is, first and foremost, a family concern. But when teenagers have babies, the consequences are felt throughout the community. Babies born to teenage parents are more likely to be low birth-weight and to suffer from inadequate health care. They also are more likely to leave high school without graduating and more likely to be poor, which leads to a cycle of unintended consequences. The potential is great with 46.8% of U.S. high school students in 2005 reporting they have ever had sexual intercourse (Figure. 8). In addition, 33.9% reported having had sexual intercourse during the previous 3 months. In Lancaster County trend data have shown a decline as 32% of high school students in 2005 reported ever having sex, down from 44.2% in 1995. Also 24.9% of teens reported having had sex in the previous 3 months in 2005, which is down slightly from 29.7% in 1995. While Lancaster County has seen positive trends in these statistics, teenage sexual activity remains a primary public health concern.

Figure 8: Sexual Activity
High School Students*



	Ever Had Intercourse	Had More Than One Sex Partner	Had Sex in Past 3 Months	First Sex at Age 12 or Younger**
1991	51.6%	34.6%	34.8%	15.7%
1993	44.9%	27.2%	30.5%	16%
1995	44.2%	27%	29.7%	15.8%
1997	46.5%	24.8%	29%	11.5%
1999	36.2%	19.2%	23.3%	13%
2001	40.7%	19.1%	23.3%	13.4%
2003	36.2%	20%	24.2%	11.6%
2005	32%	18.8%	24.9%	8%

** Students Who Reported Having Had Sex
Lincoln-Lancaster County Health Department

* Grade-adjusted

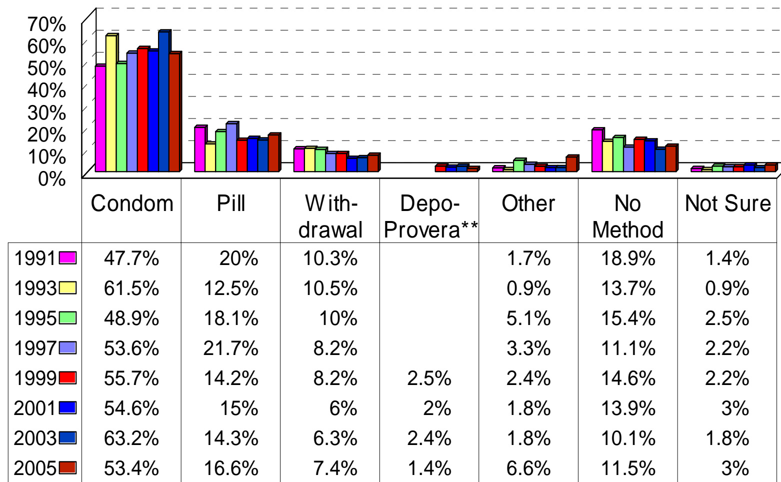
Effectively addressing teenage sexuality within the community continues to be controversial. Personal opinions often become barriers and limit an individual's willingness to seek out factual information from other individuals, advocates and agencies capable of providing education in preventing unplanned pregnancies and sexually transmitted diseases. Responsible adults and family members can convey to children, even at a young age, clear and relevant information about sexuality and appropriate sexual behavior. Such advice can counter the often one-dimensional messages and images about sex that young people hear and see in popular culture, and may result in a willingness by teenagers to postpone sexual involvement.

It must be recognized that there is no magic solution to reducing teen pregnancy, childbearing and STD rates, nor will a single intervention work for all teens. It is

essential to continue and expand a range of programs that embrace many strategies. Experts agree that holistic, comprehensive and flexible approaches are needed. The Lincoln Lancaster Teen Pregnancy Prevention Coalition is composed of a broad representation of community agencies working together to find common solutions. In addition, Abstinence Education, Male Responsibility, 40 Developmental Assets, and All Stars are among programs offered for expanding one's ability to communicate safe sexual lifestyle messages to youth.

Figure 9: Contraception Method Used During Last Sexual Intercourse*

High School Students Who Reported Having Had Sex



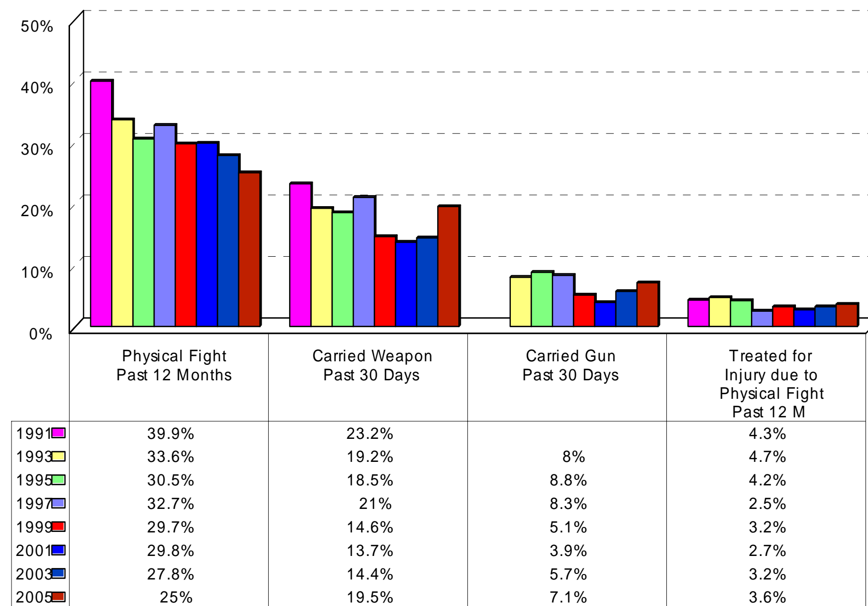
	Condom	Pill	With-drawal	Depo-Provera**	Other	No Method	Not Sure
1991	47.7%	20%	10.3%		1.7%	18.9%	1.4%
1993	61.5%	12.5%	10.5%		0.9%	13.7%	0.9%
1995	48.9%	18.1%	10%		5.1%	15.4%	2.5%
1997	53.6%	21.7%	8.2%		3.3%	11.1%	2.2%
1999	55.7%	14.2%	8.2%	2.5%	2.4%	14.6%	2.2%
2001	54.6%	15%	6%	2%	1.8%	13.9%	3%
2003	63.2%	14.3%	6.3%	2.4%	1.8%	10.1%	1.8%
2005	53.4%	16.6%	7.4%	1.4%	6.6%	11.5%	3%

* Grade-adjusted ** New response option in 1999 Lincoln-Lancaster County Health Department

Public Health Comment: Violence

Violence among children and adolescents is often overlooked as a significant public health concern. Reducing violent behavior among young people is an important process in which more people in the community need to become engaged. In 2005, a decline in violent behavior among Lancaster County high school students was observed with 25% reporting being involved in a physical fight within the previous 12 months, down from 30.5% in 1995 (Figure. 10). Because physical fights are often so common, many people dismiss them as normal part of growing up. While it is true that teens have always engaged in fistfights, a slight increase in the number of teens carrying deadly weapons is a concern.

Figure 10: Violence*
High School Students



	Physical Fight Past 12 Months	Carried Weapon Past 30 Days	Carried Gun Past 30 Days	Treated for Injury due to Physical Fight Past 12 M
1991	39.9%	23.2%		4.3%
1993	33.6%	19.2%	8%	4.7%
1995	30.5%	18.5%	8.8%	4.2%
1997	32.7%	21%	8.3%	2.5%
1999	29.7%	14.6%	5.1%	3.2%
2001	29.8%	13.7%	3.9%	2.7%
2003	27.8%	14.4%	5.7%	3.2%
2005	25%	19.5%	7.1%	3.6%

Lincoln-Lancaster County Health Department

*Grade Adjusted

The origins of youth violence stem from environmental, social, physical and mental factors. Effective programs combine components that address both individual risks and environmental conditions, particularly building individual skills and competencies, parent effectiveness training, improving the social climate of the school, and changes in type and level of involvement in peer groups. We can teach young people how to avoid violent situations and help them develop the skills they need to resolve conflicts without resorting to violence. We can help parents provide a nonviolent home for their children and we can provide young people with mentors who serve as nonviolent role models. Too many factors contribute to violent behavior to be addressed by only one strategy. The most effective programs include several types of these interventions and strategies that complement one another.

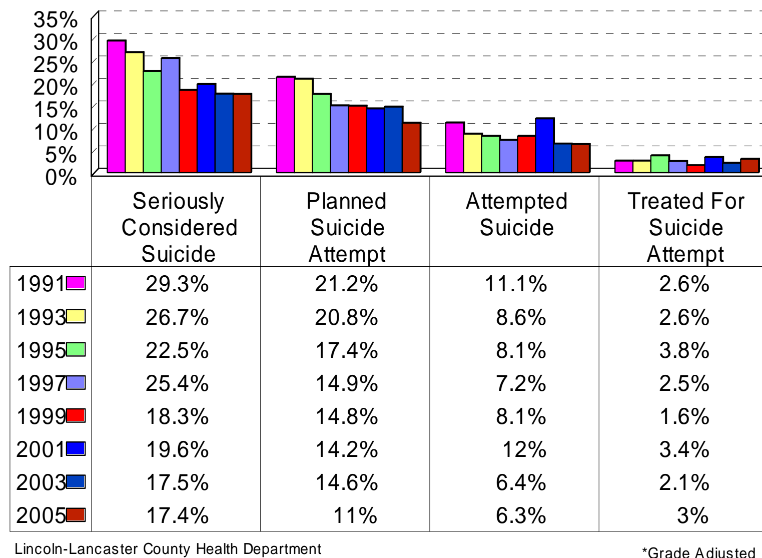
Children learn by watching us solve problems with respectful words and nonviolent actions. The most important way to teach children how to handle anger is to show that we can calm ourselves, think about our own actions, and take reasonable, nonviolent

steps to change the situation that made us angry. Only when we respond to anger in a calm, respectful manner can we begin to help children control their own angry feelings. Prevent Child Abuse Nebraska's focus is on primary prevention of child abuse and neglect through educational programs and public awareness campaigns. Local grassroots organizations and groups like the Lincoln-Lancaster Community Child Abuse Prevention Council work together to learn how best to prevent abuse from occurring and provide assistance in developing effective abuse prevention programs, so that other family service organizations in the community can be as proficient as possible while providing direct services.

Public Health Comment: Suicide

Nationally, suicide is the third leading cause of death for young people aged 15 to 24. Most suicidal persons desperately want to live, but they are unable to see alternatives to their problems. Most of them also give definite warnings of their suicidal thoughts. However, those closest to them are either unaware of the significance of these warnings or do not know how to respond to them. Fortunately, the number of Lancaster County high school students that have seriously considered or attempted suicide has been declining. In 1995, 22.5% of students reported seriously considering suicide and 8.1% reported attempting suicide. In 2005, those numbers are down as 17.4% of students reported that they had seriously considered suicide while 6.3% stated they had attempted suicide (Figure. 11).

Figure 11: Suicide Ideation and Attempts*
High School Students, Reported During the Past 12 Months



	Seriously Considered Suicide	Planned Suicide Attempt	Attempted Suicide	Treated For Suicide Attempt
1991	29.3%	21.2%	11.1%	2.6%
1993	26.7%	20.8%	8.6%	2.6%
1995	22.5%	17.4%	8.1%	3.8%
1997	25.4%	14.9%	7.2%	2.5%
1999	18.3%	14.8%	8.1%	1.6%
2001	19.6%	14.2%	12%	3.4%
2003	17.5%	14.6%	6.4%	2.1%
2005	17.4%	11%	6.3%	3%

Lincoln-Lancaster County Health Department

*Grade Adjusted

Suicide is a complex behavior that requires intense preventive measures. The fact that many teenagers engage in risky behaviors that greatly increase their likelihood of death leads some health experts to believe that such behaviors may be suicidal in nature. For example, high school students who engage in substance abuse and/or sexual activity are more likely to attempt suicide than those that avoid those behaviors. Scientific research has shown that recognition and appropriate treatment of mental health and substance abuse disorders is the most promising way to prevent suicide and suicidal behavior in all age groups.

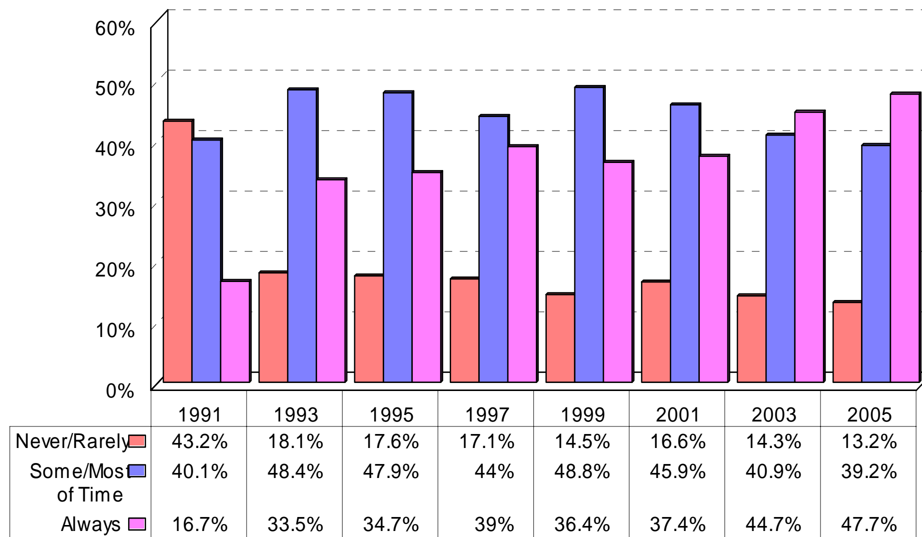
Nebraska began forming action groups in 1999 to look at suicide prevention planning. The action groups organized suicide prevention activities around the Surgeon General's recommendations for action. The Nebraska State Suicide Prevention Committee (NSSPC) has three subcommittees, Awareness, Intervention, and Methodology. For more information please visit: www.hhs.state.ne.us/beh/mh/suicide.htm

Public Health Comment: Seatbelt and Helmet Use

Unintentional injury is the leading cause of death for adolescents in the United States. More than 4,000 youth 11 to 18 years of age die each year in motor vehicle crashes, making this category the leading cause of adolescent unintentional injury death. Occupant restraints (seatbelts) are proven to reduce the risk of death and serious injury in a crash by 55% when used properly. In 2005, only 47.7% of Lancaster County youth surveyed reported always wearing a seatbelt when riding with someone else (Figure. 12).

Figure 12: Seatbelt Use*

High School Students Who Rode With Someone Else



	1991	1993	1995	1997	1999	2001	2003	2005
Never/Rarely	43.2%	18.1%	17.6%	17.1%	14.5%	16.6%	14.3%	13.2%
Some/Most of Time	40.1%	48.4%	47.9%	44%	48.8%	45.9%	40.9%	39.2%
Always	16.7%	33.5%	34.7%	39%	36.4%	37.4%	44.7%	47.7%

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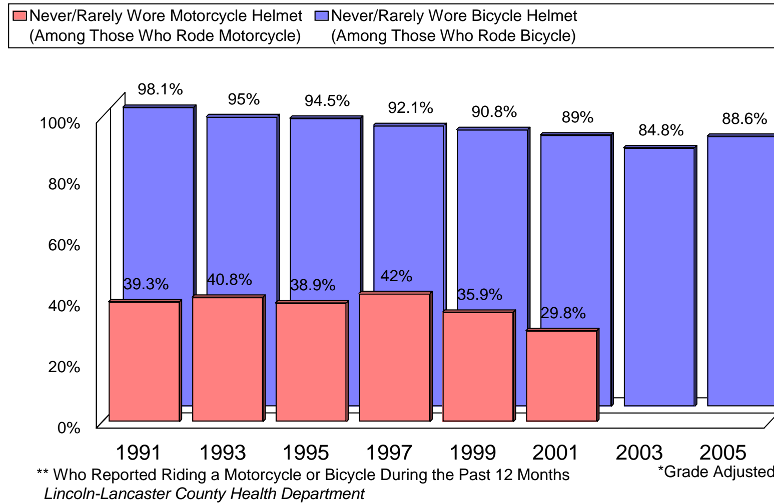
Head injury is the leading cause of death and disability in bicycle crashes. Over 322,000 youth were injured in pedal-cycle crashes during a two year period, 2003-2004. Children and youth are 14 times more likely to survive a bike crash if they are wearing a helmet. However, in 2005, 88.6% of Lancaster County high school students surveyed who rode a bicycle during the past 12 months never or rarely wore a bicycle helmet (Figure. 13).

Community education and enforcement efforts have had some positive impact on rates of seatbelt and helmet use by youth. However, usage rates of seatbelts and helmets among youth remain disproportionately low as compared to other age groups. The personal and economic costs paid by individuals and the community for these injuries warrant an increased commitment to prevent them by families, safety advocates, and public and private sector organizations.

Figure 13: Helmet Use*

High School Students**

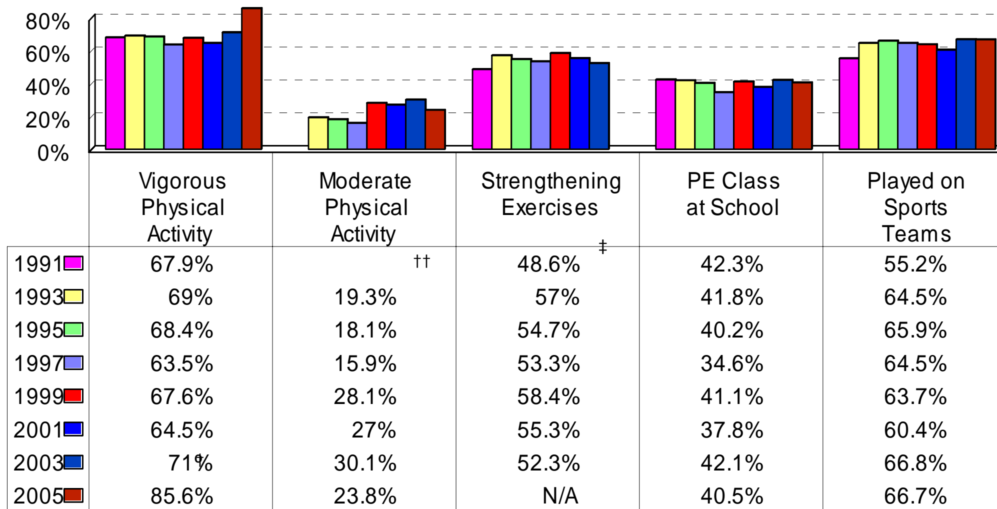


The Lincoln-Lancaster County SAFE KIDS Coalition is comprised of individuals representing the public and private sectors and is committed to addressing occupant restraint and helmet use among our children and youth. The Coalition's Child Passenger Safety Task Force provides education and services to parents with the intent of creating a high priority early in the child's life of consistent use of occupant restraints that will continue through the teen and adult years. The Coalition's Sports and Wheeled Sports Task Force works with middle schools to conduct presentations on the importance of helmet use and provides free helmets to students pledging to wear them. This task force also works with state and local policy makers in an effort to introduce and strengthen bicycle safety and helmet use policies.

Public Health Comment: Physical Activity

The scientific evidence continues to grow regarding the positive correlation between physical activity and health outcomes. People who start a regular, moderately intense routine of physical activity in their youth and maintain it into adulthood are healthier, happier, and more productive individuals. Fortunately, Lancaster County has seen an increase in moderate physical activity among high school students with 61.8% of them reporting they had exercised in the past 30 days in 2005, up from 52.5% in 1995 (Figure. 14).

Figure 14: Physical Activity*
High School Students



	Vigorous Physical Activity	Moderate Physical Activity ††	Strengthening Exercises ‡	PE Class at School	Played on Sports Teams
1991	67.9%		48.6%	42.3%	55.2%
1993	69%	19.3%	57%	41.8%	64.5%
1995	68.4%	18.1%	54.7%	40.2%	65.9%
1997	63.5%	15.9%	53.3%	34.6%	64.5%
1999	67.6%	28.1%	58.4%	41.1%	63.7%
2001	64.5%	27%	55.3%	37.8%	60.4%
2003	71%	30.1%	52.3%	42.1%	66.8%
2005	85.6%	23.8%	N/A	40.5%	66.7%

† physical activity that made you sw eat and breathe hard for at least 20 minutes, on 3 or more of the previous 7 days
†† physical activity that did not make you sw eat or breathe hard,for at least 30 minutes, on 5 or more of the previous 7 day
‡ strenghened or toned muscles, on 3 or more of the previous 7 days
‡‡ have physical education class on 1 or more days in average w eek at school
‡‡‡ played on 1 or more sports teams in the past 12 months, either run by school or community groups

Lincoln-Lancaster County Health Departm ent

*Grade Adjusted

Families are key to increasing physical activity by modeling and supporting participation in physical activity programs and initiatives. Schools are essential to the effort by including quality, daily physical and health education, recess, and extracurricular activities to develop the knowledge, attitude, skills, behaviors, and confidence to adopt and maintain physically active lifestyles. A community structural environment that makes it easy and safe for young people to walk, ride bikes, and use close-to-home physical activity facilities is also essential.

In May 2003, the Governor's Council on Health Promotion and Physical Fitness released a document that outlined what can realistically be addressed by communities across the state to enhance efforts and promote a more active lifestyle for Nebraska's youth. Strategies regarding families, schools and communities were included with all of them designed to promote lifelong participation in enjoyable and safe physical activity.

Public Health Comment: Body Weight and Weight Loss

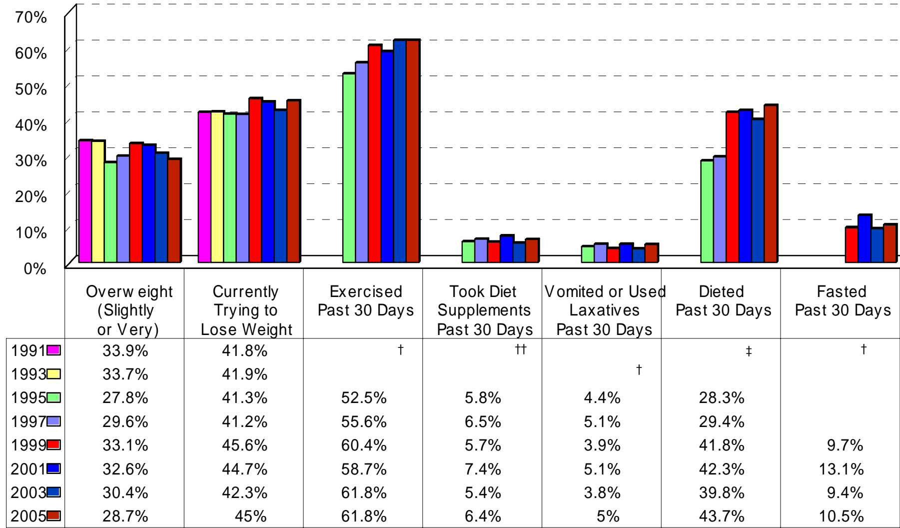
The trend for students identifying themselves as slightly or very overweight has remained constant at about 33% for over a decade. However, the percentage of high school students identifying themselves as having exercised in the past 30 days in order to lose weight exceeds 40% (Figure. 15). This suggests that there is another reason other than health for trying to change their body weight. In nearly every response of the survey regarding body weight and behaviors, girls are more likely than boys to have an unhealthy view of their body weight and exhibit behaviors directed at changing their body weight. While a significant number of high school students need to be concerned with their body weight and develop positive behaviors to reduce their body weight, too many are focusing on their body weight for cosmetic or body image reasons and not for health reasons.

Looking over the past 10 years at the rate of high school students that identified themselves as currently trying to lose weight, girls have been three times more likely than boys to identify themselves in that manner. However, in that same time period, girls have been only twice as likely to identify themselves as being slightly or very overweight. In turn, girls are also twice as likely as boys to claim they have exercised in the past 30 days to lose weight and three times more likely to have dieted in the past 30 days to lose weight.

Healthy eating behaviors, similar to physical activity behaviors, start at a young age. The youth of Lancaster County model behavior that they see in their homes and make nutritional choices based on what is offered for meals and snacks at their schools. For these reasons, it is most important to create more environments that provide healthy eating choices to positively affect the lifelong health outcomes of youth in our community.

Figure 15: Body Weight & Weight Loss Behaviors*

High School Students



	Overweight (Slightly or Very)	Currently Trying to Lose Weight	Exercised Past 30 Days	Took Diet Supplements Past 30 Days	Vomited or Used Laxatives Past 30 Days	Dieted Past 30 Days	Fasted Past 30 Days
1991	33.9%	41.8%	†	††		‡	†
1993	33.7%	41.9%			†		
1995	27.8%	41.3%	52.5%	5.8%	4.4%	28.3%	
1997	29.6%	41.2%	55.6%	6.5%	5.1%	29.4%	
1999	33.1%	45.6%	60.4%	5.7%	3.9%	41.8%	9.7%
2001	32.6%	44.7%	58.7%	7.4%	5.1%	42.3%	13.1%
2003	30.4%	42.3%	61.8%	5.4%	3.8%	39.8%	9.4%
2005	28.7%	45%	61.8%	6.4%	5%	43.7%	10.5%

† "to lose weight or keep from gaining weight"

†† "took diet pills, powders, or liquids without a doctor's advice to lose weight (does not include meal replacement products)"

‡ 1999: "ate less food, fewer calories, or foods low fat to lose weight or keep from gaining wei
1997, 1995: "dieted"

* Grade Adjusted

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