

HEALTH STATUS - ADOLESCENTS



SEXUAL ACTIVITY AND EDUCATION

In 2011, 47.4 percent of high school students reported having had sexual intercourse at least once, while the remaining 52.6 percent were abstinent. Sexual activity increased with grade level: 32.9 percent of 9th grade students reported having had sexual intercourse, compared to 43.8 percent of 10th graders, 53.2 percent of 11th graders and 63.1 percent of 12th graders (data not shown). Within each grade, no difference was observed between males and females in the proportion having had sexual intercourse, with the exception of 9th grade, where males were significantly more likely to report having had sexual intercourse than females (37.8 versus 27.8 per-

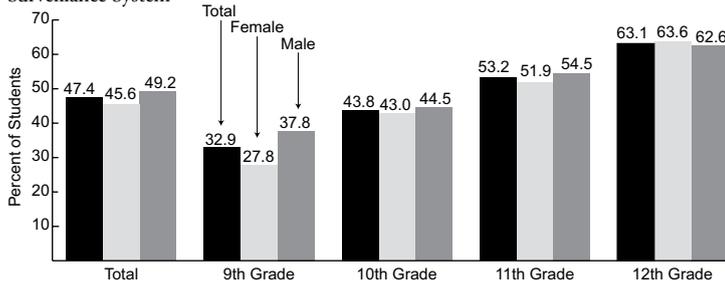
cent). Males were also significantly more likely to report having had sexual intercourse for the first time before age 13 than females (9.0 versus 3.2 percent; data not shown).

Contraceptive use also varies significantly by sex. Overall, 67.0 percent of males and 53.6 percent of females reported condom use at last intercourse. Use of a hormonal contraceptive (by self or partner) was less common than condom use and was reported by 16.6 percent of males and 30.0 percent of females. Less than 10 percent of adolescents used both a condom and a form of hormonal contraception during last sexual intercourse. Among females, 15.1 percent reported not using any method to prevent pregnancy at last sexual intercourse, compared to 10.6 percent of males.

According to data from the National Survey of Family Growth, 16 percent of females and 28 percent of males had their first experience of sexual intercourse with someone they had just met or with whom they were “just friends” (data not shown).⁵⁴ There were large differences by race and ethnicity in the percentage of females whose first sex was with someone they were not regularly involved with. Hispanic female teenagers were less likely than their non-Hispanic White or non-Hispanic Black counterparts to have had first sex with someone they had just met (8.7, 16.0, and 21.0 percent, respectively). There was no significant difference between non-Hispanic Black and non-Hispanic White females in the percentage who had “just met” their first sexual partner.

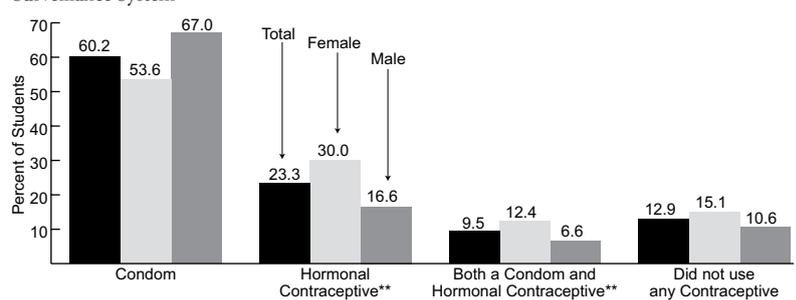
High School Students Who Have Ever Had Sexual Intercourse, by Sex and Grade Level, 2011

Source (II.16): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



Contraceptive Method Used* Among High School Students Who Are Currently Sexually Active, by Sex, 2011

Source (II.16): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Used during last sexual intercourse by student or their partner. **Hormonal contraceptive refers to birth control pills, Depo-Provera or other injectable, Nuva Ring or other birth control ring, Implanon or other implant, or any IUD.

ADOLESCENT CHILDBEARING

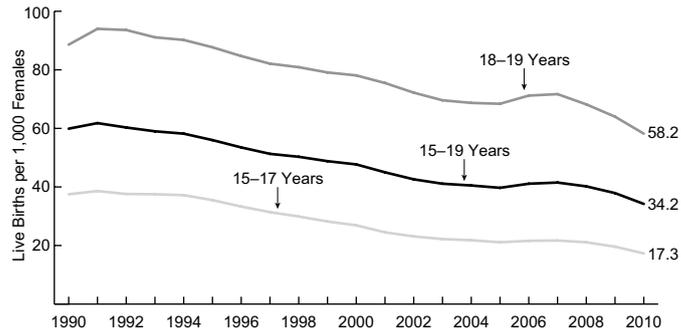
In 2010, the birth rate among adolescent females aged 15–19 years decreased to 34.2 per 1,000 females—the lowest rate ever recorded. This continues the general decline in teen birth rates since the most recent peak in 1991, when the rate was 61.8 per 1,000 females, and represents a decline of 44 percent over that period. In 2010, the birth rate among adolescents aged 15–17 years was lower than for 18– to 19-year-olds (17.3 versus 58.2 births per 1,000) and adolescents aged 15–17 years experienced larger declines in childbearing from the 1991 peak compared with 18– to 19-year-olds (55 versus 38 percent).

Although adolescent birth rates reached historic lows for all race and ethnic groups in 2010, disparities remained. Among adolescents aged 15–19 years, Hispanic and non-Hispanic Black females had the highest birth rates in 2010 (55.7 and 51.5 births per 1,000)—rates more than five times higher than those of Asian/Pacific Islander females (10.9 births per 1,000) and twice as high as non-Hispanic White females (23.5 births per 1,000). American Indian/Alaska Native adolescents aged 15–19 years also had higher birth rates (38.7 births per 1,000) than Asian/Pacific Islander and non-Hispanic White females. These disparities persist for both younger and older adolescents, aged 15–17 years and 18–19 years, respectively.

Declines in adolescent childbearing over the past two decades have been attributed to delays in the age at first intercourse and increased use of highly effective contraceptive methods, including IUDs or hormonal methods.⁵⁵ Racial and ethnic disparities in the age of sexual debut have been eliminated due to delays in sexual initiation for non-Hispanic Black and Hispanic females compared with non-Hispanic White females. However, racial and ethnic disparities in contraceptive use persist. In 2006–2010, 65.7 percent of sexually active non-Hispanic White adolescent females used highly effective contraceptive methods, compared to 46.5 percent non-Hispanic Black and 53.7 percent of Hispanic adolescent females (data not shown).⁵⁵

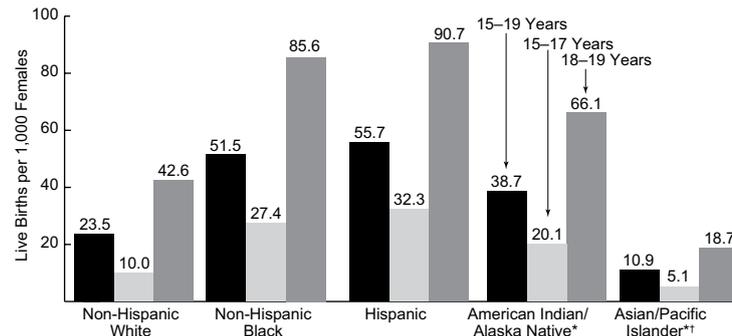
Birth Rates Among Adolescent Females Aged 15–19 Years, 1990–2010

Source (II.1, II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Birth Rates Among Adolescent Females Aged 15–19 Years, by Race/Ethnicity* and Age, 2010

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*May include Hispanics.

†Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs), such as chlamydia, gonorrhea, and genital human papillomavirus (HPV) can pose serious, long-term health complications for adolescents and young adults.⁵⁶ Although young people aged 15–24 years represent only one-quarter of the sexually experienced population, they acquire nearly half of all new STIs.⁵⁷

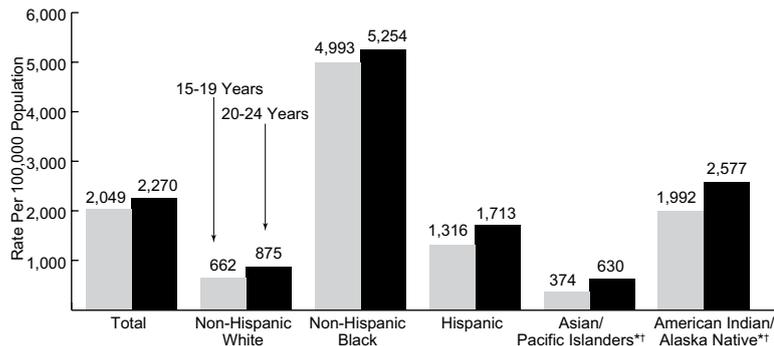
Among adolescents and young adults, Chlamydia continues to be the most common of all the STIs reported to the Centers for Dis-

ease Control and Prevention (CDC). There were 2,049 chlamydial infections per 100,000 adolescents aged 15-19 years and 2,270 per 100,000 young adults aged 20-24 years in 2010. Gonorrhea was less common, with rates of 410 and 490 per 100,000 in these age groups, respectively. Rates for both diseases vary by race and ethnicity. Among adolescents aged 15-19 years, the highest rate of chlamydia was reported among non-Hispanic Blacks (4,993 per 100,000), followed by American Indian/Alaska Natives (1,992 per 100,000). Rates of gonorrhea were also highest among these two racial/ethnic groups for adolescents and young adults.

Unlike chlamydia and gonorrhea, HPV infections are not required to be reported to the CDC; however, persistent infection of specific types of HPV can lead to cancer.⁵⁸ The overall prevalence of all types of HPV among females aged 14-59 is estimated to be 42.5 percent.⁵⁹ A vaccine for certain types of HPV was approved in 2006 for use in females aged 9–26 years and licensed in October 2009 for use in males aged 9-26 years.⁶⁰ In 2010, 53.0 percent of females aged 13–17 years had received at least one dose of the three-dose series.⁶¹

Reported Chlamydia Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity, 2010

Source (II.17): Centers for Disease Control and Prevention, STD Surveillance System

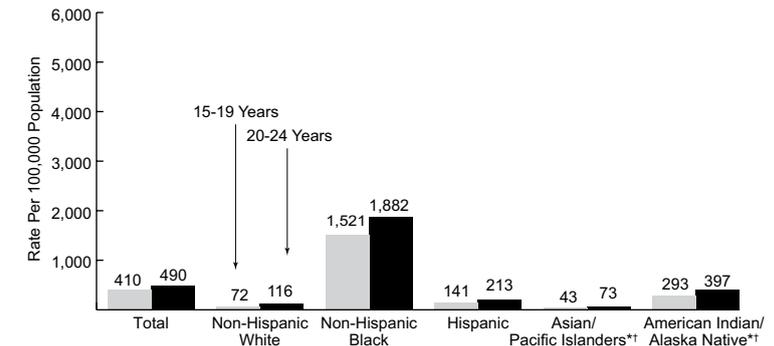


*Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

**May include Hispanics.

Reported Gonorrhea Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity, 2010

Source (II.17): Centers for Disease Control and Prevention, STD Surveillance System



*Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

**May include Hispanics.

ADOLESCENT AND YOUNG ADULT HIV AND AIDS

Human immunodeficiency virus (HIV) is a disease that destroys cells that are critical to a healthy immune system. Acquired immunodeficiency syndrome (AIDS) is diagnosed when HIV has weakened the immune system enough that the body has difficulty fighting disease and infections. HIV prevention is a particularly important issue for adolescents and young adults, as these groups experience the majority of new HIV infections. In 2009, those aged 15–29 accounted for 39 percent of all new HIV infections in the U.S., while this age group represented 21 percent of the U.S. population in 2010.⁶² Early age at sexual initiation, unprotected sex, drug use, older sex partners and lack of awareness places adolescents at an increased risk of contracting HIV.

In 2009, more than 37,000 adolescents and young adults between 13–24 years of age were living with a diagnosed HIV infection. Between 2007 and 2010, the rate of diagnosed HIV infection remained stable for younger adolescents (aged 13–14 years) while increasing for those aged 15–24 years (data not shown). A similar pattern by age group was observed for the rate of AIDS diagnosis, with rates increasing for those aged 15–24 years. In 2009, 11,094 persons aged 13–24 years were living with an AIDS diagnosis. Between 2007 and 2009, the rate of deaths with an AIDS diagnosis remained stable for the U.S.

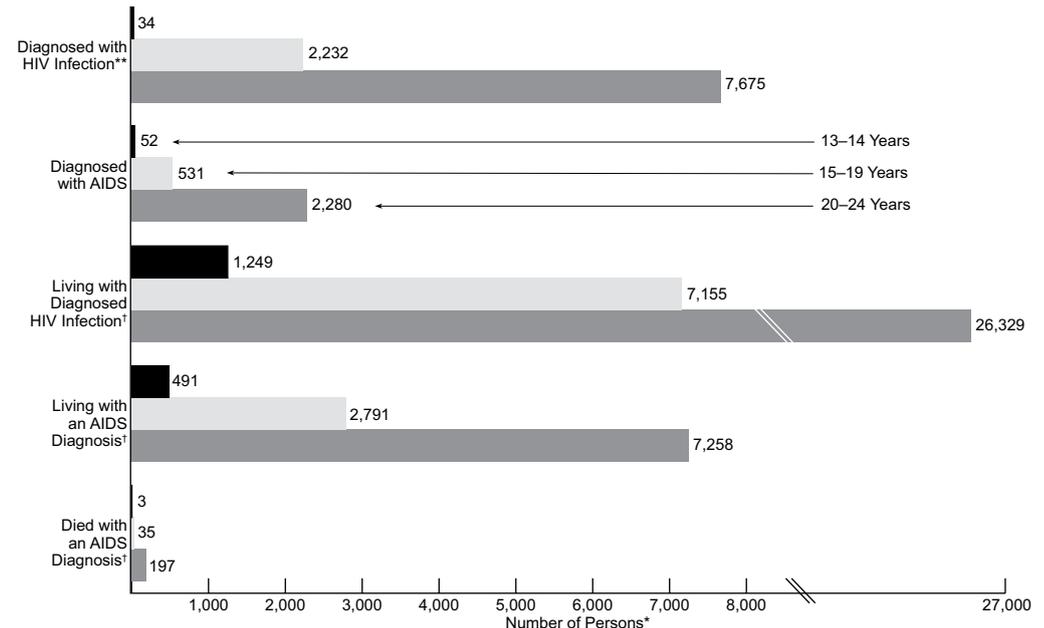
population as a whole, but increased among persons aged 20–24 years (data not shown).

Abstaining from sex and drug use is the most effective way to avoid HIV infection. Adolescents and young adults can also reduce their risks by informing themselves of how to negotiate safer sex, where to get tested for HIV, and

how to use a condom correctly. The CDC has developed interventions that can be carried out locally to help reduce the risk to adolescents. One such program, *Choosing Life: Empowerment! Action! Results!*, is for those older than 16 years of age and living with HIV infection or AIDS or at high risk for HIV.⁶³

Selected Data on HIV* and AIDS Among Adolescents and Young Adults, by Age, 2009

Source (II.18): Centers for Disease Control and Prevention. HIV Surveillance Report, 2010



*Estimated numbers reflect statistical adjustment for reporting delays and missing risk-factor information, but not for incomplete reporting. Data for United States and dependent areas. **Estimates for 2010. †Estimates for 2009.

PHYSICAL ACTIVITY

The U.S. Department of Health and Human Services recommends that children and adolescents get 1 hour or more of physical activity every day, most of which should be moderate- to vigorous-intensity aerobic activity.⁶⁴ Data from the 2011 Youth Risk Behavior Surveillance System showed that 28.7 percent of high school students were physically active for at least 60 minutes on each of the 7 previous days. This represents an increase in adolescent physical activity from the 2009 level of 19.4 percent.

Overall, 13.8 percent of students did not participate in 60 or more minutes of physical activity on any day in the preceding week. The rate was higher for females (17.7 percent) than males (10.0 percent) and among Asian (22.2 percent), non-Hispanic Black (19.6 percent), and Hispanic (15.9 percent) high school students compared to non-Hispanic Whites (11.0 percent; data not shown).

Participation in recommended levels of physical activity varied by sex and grade level. Among high school students in all grades, a smaller proportion of females reported 60 minutes of physical activity on each of the previous seven days than males. Among 9th graders, 22.2 percent of females achieved recommended levels of physical activity, compared to 38.8 percent of their male counterparts. By 12th grade, only 14.9 percent of females met the recom-

mended levels compared to 34.9 percent of males in the same grade.

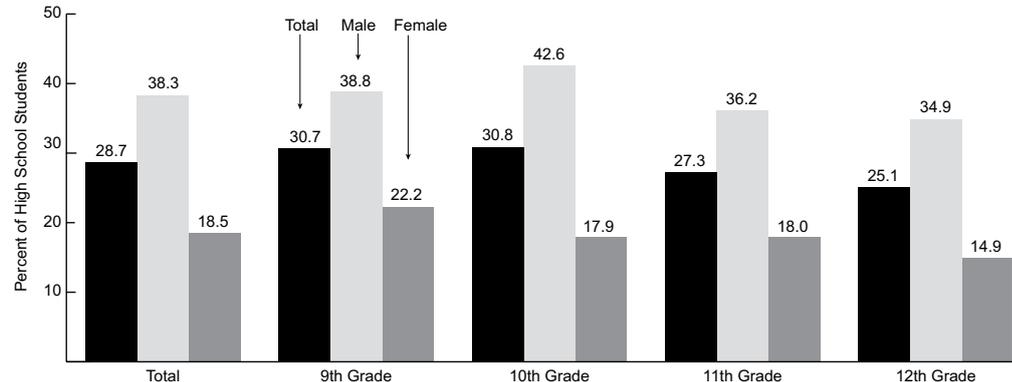
In 2011, 51.8 percent of high school students attended physical education (PE) classes at least one day per average school week. The rate decreased with each grade level: 68.1 percent of 9th grade students attended PE class on one or more days in an average week, while the same was true for 54.6 percent of 10th graders, 42.9 percent of 11th graders and 38.5 percent of 12th grade students. Overall, only 31.5 percent of high school students attended daily PE classes in 2011 (data not shown).

In 2011, 58.4 percent of high school students reported playing on at least one sports

team in the past year. This was more common among younger adolescents than older adolescents (61.4 percent of 9th graders compared to 52.5 percent of 12th graders). Sports participation also varied by sex. Just over one-half of adolescent females (52.6 percent) reported playing on at least one sports team in the past year, compared to 64.0 percent of males. These differences increased with age: while 57.1 percent of 9th grade females reported sports participation in 2011, only 44.5 percent of 12th grade females did so. Among males, the rates of past-year sports team participation declined from 65.6 percent among 9th graders to 60.2 percent among 12th graders (data not shown).

Physical Activity* Among High School Students, by Sex and Grade Level, 2011

Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



*Defined as physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes on each of the last 7 days.

SEDENTARY BEHAVIORS

The American Academy of Pediatrics recommends that parents limit children's media time to 1–2 hours per day.⁶⁵ This includes time spent watching TV or videos as well as time spent playing video games. In 2011, 32.4 percent of high school students reported watching 3 or more hours of television per day on an average school day. There was no significant difference in the proportion of males and females who reported this behavior. However, younger students, those in 9th grade, were slightly more likely to watch 3 or more hours of television (33.9 percent) than the oldest students, those in 12th grade (30.4 percent; data not shown).

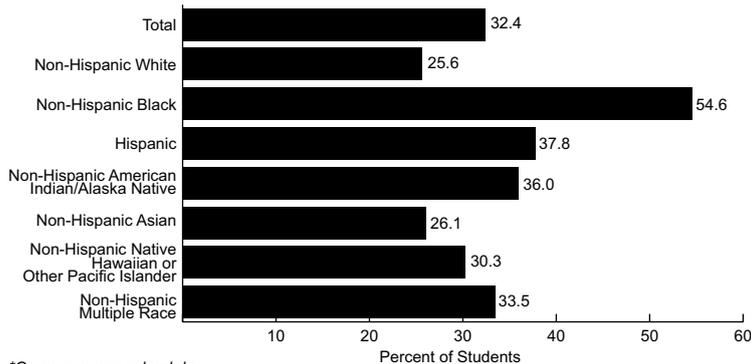
The proportion of students who reported 3 or more hours of television watching varied significantly by race/ethnicity. Over half (54.6 percent) of non-Hispanic Black students reported this behavior, while the same was true for about one-quarter of non-Hispanic White and Asian students (25.6 percent and 26.1 percent, respectively), and slightly more than one-third of Hispanic (37.8 percent) and non-Hispanic American Indian/Alaska Native (36.0 percent) students.

In the same year, nearly one-third (31.1 percent) of high school students reported using computers for something other than school work, such as video or computer games, for 3 or

more hours per day on an average school day. The proportion varied by sex and grade level. Overall, males were more likely to report non-school related computer usage of 3 or more hours than females (35.3 percent versus 26.6 percent) as were 9th grade students (32.5 percent) compared to those in 12th grade (28.8 percent). Across all grade levels, a greater proportion of males reported 3 or more hours of daily non-school related computer use during weekdays. Daily computer use also varied by race/ethnicity, with non-Hispanic Asians and Blacks more likely to report this level of computer use than non-Hispanic White or Hispanic students (data not shown).

High School Students Who Watched 3 or More Hours of Television per Day,* by Race/Ethnicity, 2011

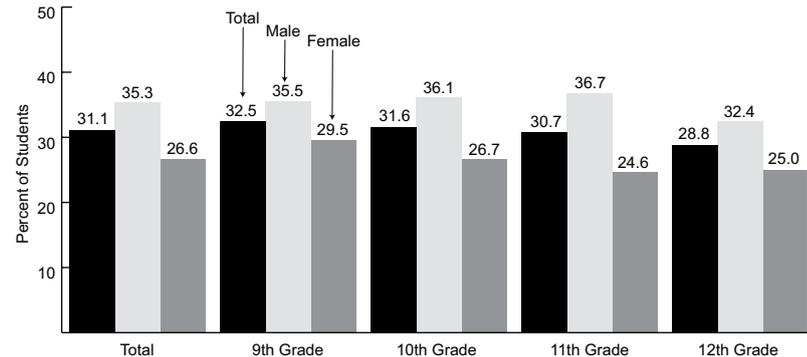
Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



*On an average school day.

High School Students Who Used Computers for 3 or More Hours per Day for Something Other than School Work,* by Sex and Grade, 2011

Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



*On an average school day.

DIETARY BEHAVIORS

The *Dietary Guidelines for Americans 2010* recommends eating a variety of nutrient-dense foods and beverages while maintaining calorie balance to reach and maintain a healthy weight. The *Guidelines* encourage all individuals aged 2 years and older to consume a variety of fruits and vegetables, whole grains, fat-free or low-fat milk products, as well as a variety of protein foods, including seafood, lean meats and poultry, eggs, beans and peas, soy products, and nuts and seeds, while limiting sodium, solid fats, added sugars, and refined grains.⁶⁶

In 2011, 5.7 percent of high school students reported that they did not eat any vegetables during the past 7 days, while 11.7 percent reported that they did not eat any fruit during the past week. Overall, males were more likely than females to report no vegetable or fruit consumption in the past week (6.9 percent versus 4.5 percent and 12.6 percent versus 10.7 percent, respectively; data not shown). The proportion of adolescents who reported neither vegetable nor fruit consumption also varied by race and ethnicity. Non-Hispanic White and Asian students were generally less likely to report no vegetable consumption than non-Hispanic Black and Hispanic students. Non-Hispanic Blacks were also more likely to report no fruit consumption in the past week.

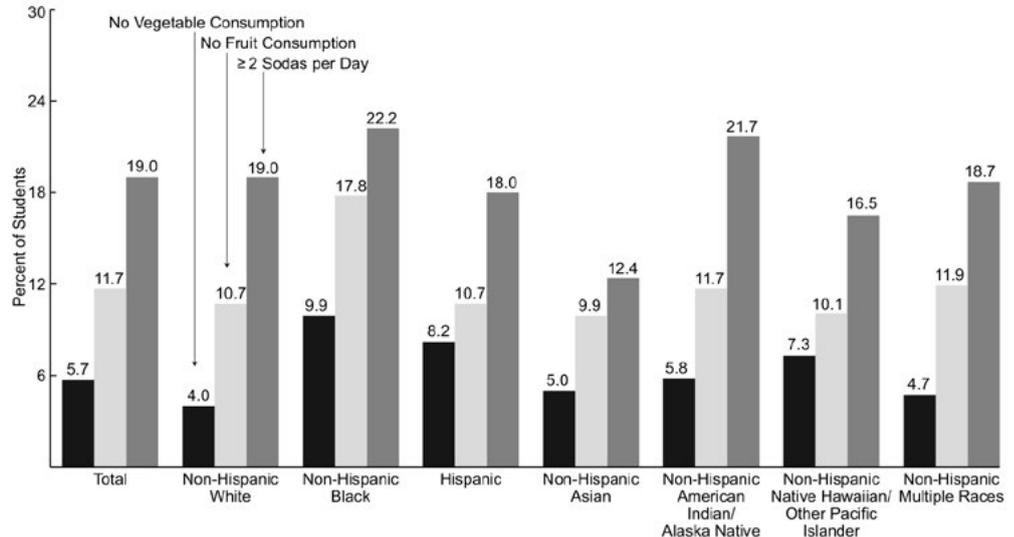
Overall, 15.3 percent of high school students reported eating vegetables three or more times per day and nearly one-quarter (22.4 percent) reported eating fruit or drinking 100% fruit juice three or more times per day in the past 7 days. Males were more likely to report this level of fruit and vegetable consumption than females; no trends were observed by grade level (data not shown).

Because soda, energy drinks, and sports drinks are a major source of added sugar for Americans, the Guidelines recommend limit-

ing the consumption of such beverages in order to lower calorie consumption. In 2011, nearly one-fifth (19.0 percent) of high school students drank two or more cans, bottles or glasses of soda per day during the last 7 days.⁶⁷ Males were more likely than females to consume two or more sodas a day (21.8 percent versus 16.1 percent; data not shown). Few racial/ethnic differences were observed, with the notable exception of non-Hispanic Asian students, of whom only 12.4 percent reported consuming this amount of soda.

High School Students Who Engaged in Selected Dietary Behaviors, by Race/Ethnicity, 2011

Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



OVERWEIGHT AND OBESITY

Body mass index (BMI) is the ratio of weight to height, which is used to define overweight and obesity as well as normal weight status and underweight. In children, BMI is used in conjunction with age and sex, since both of these factors affect body composition. Children who fall between the 85th and 94th percentile of BMI-for-age are considered overweight, while children who are in the 95th percentile or above are considered obese; those who fall below the 5th percentile are considered underweight and those between the 5th and 84th percentile are considered to be normal weight. In 2009–10,

14.7 percent of children aged 2–19 years were overweight, 16.9 percent were obese, 64.1 percent were normal weight, and 4.3 percent were underweight based on measured height and weight (data not shown).

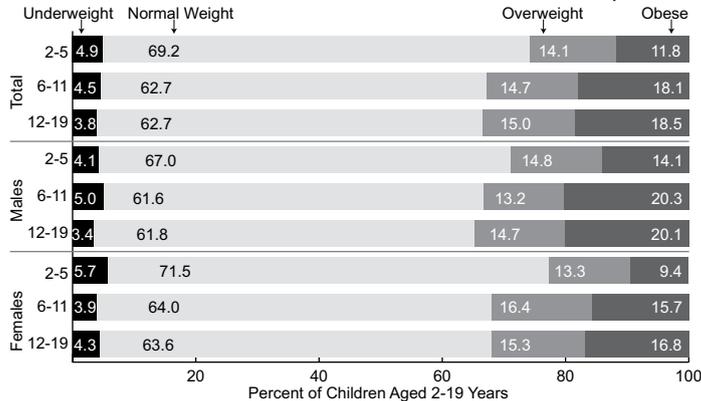
Weight status among children varies by a number of factors, including age and sex, race/ethnicity, and household income. School-aged children were more likely to be obese than preschool-aged children: approximately 18 percent of children aged 6–11 years and 12–19 years were considered to be obese, compared to 11.8 percent of children aged 2–5 years.

The prevalence of overweight and obesity

also varied by race/ethnicity. Nearly one-quarter of non-Hispanic Black children were considered to be obese in 2009–10 and another 15 percent considered to be overweight. Similarly, nearly 40 percent of Mexican-American and other Hispanic children were either overweight or obese. In comparison, approximately 28 percent of non-Hispanic White children were overweight or obese. Racial/ethnic differences were particularly pronounced among females: between 18–24 percent of non-Hispanic Black, Mexican-American, and other Hispanic girls were obese, compared to 11.5 percent of their non-Hispanic White counterparts.

Weight Status* Among Children Aged 2-19 Years, by Age and Sex, 2009-10

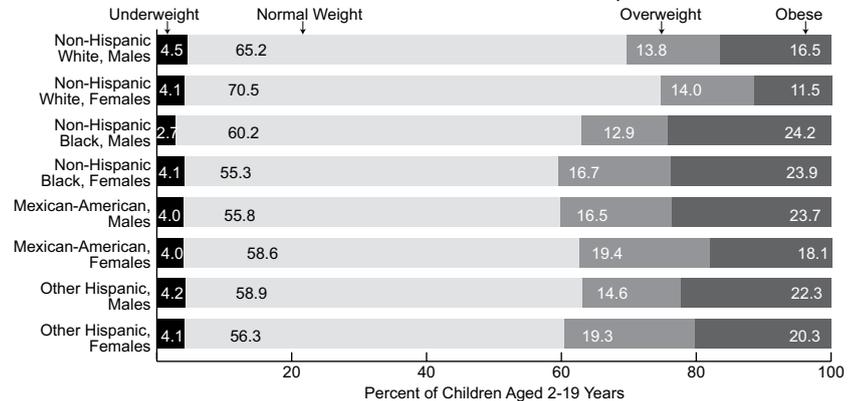
Source (II.15): CDC, National Health and Nutrition Examination Survey



*Underweight is a BMI-for-age under the 5th percentile, normal weight is a BMI-for-weight between the 5th and 84th percentile, overweight is a BMI-for-age between the 85th and 94th percentile, and obesity is a BMI-for-age in the 95th percentile or above; based on parent-reported height and weight.

Weight Status* Among Children Aged 2-19 Years, by Race/Ethnicity and Sex, 2009-10

Source (II.15): CDC, National Health and Nutrition Examination Survey



*Underweight is a BMI-for-age under the 5th percentile, normal weight is a BMI-for-weight between the 5th and 84th percentile, overweight is a BMI-for-age between the 85th and 94th percentile, and obesity is a BMI-for-age in the 95th percentile or above; based on parent-reported height and weight.

WEIGHT CONTROL BEHAVIORS

In 2011, 46.0 percent of high school students reported that they were trying to lose weight. Nearly twice as many adolescent females (61.2 percent) reported that they were trying to lose weight as males (31.6 percent); this ratio persisted across all grade levels (data not shown). Non-Hispanic Black students were less likely to report trying to lose weight (40.9 percent) than non-Hispanic Whites (44.8 percent), and Hispanic students (52.6 percent). Among all racial/ethnic groups, with the exception of non-Hispanic American Indian/Alaska Native students,

females were more likely to report trying to lose weight than males.

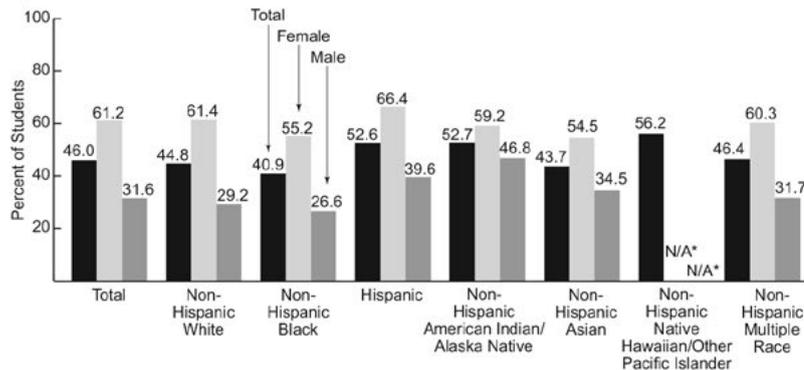
The Youth Risk Behavior Surveillance System asked students about behaviors to lose or keep from gaining weight in the 30 days prior to the survey: fasting for 24 hours or more, taking supplements, including diet pills, powders or liquids, and vomiting or taking laxatives. Overall, 12.2 percent, 5.1 percent, and 4.3 percent of high school students reported engaging in each of these behaviors, respectively.

The proportion of students reporting each of these behaviors was similar across grade

level; however, significant sex differences were observed. For example, more than twice as many females reported fasting for 24 hours or more than males (17.4 percent compared to 7.2 percent) and 6.0 percent of females reporting vomiting or taking laxatives, compared to 2.5 percent of males. The prevalence of weight control behaviors also varied by race/ethnicity. Non-Hispanic American Indian/Alaska Native students were more likely than non-Hispanic Black, Asian, and White students to report either fasting for 24 hours or more or vomiting/taking laxatives (data not shown).

High School Students Who Tried to Lose Weight in the Past 12 Months, by Race/Ethnicity and Sex, 2011

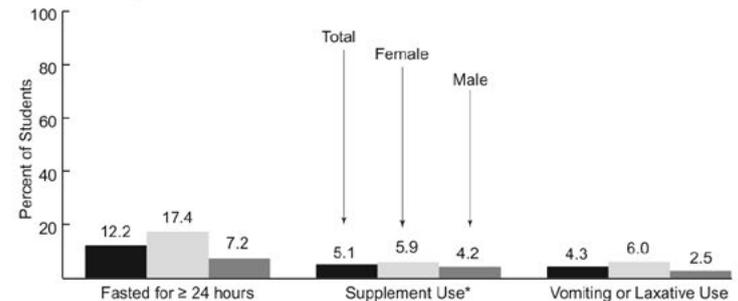
Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Sex-specific data for Native Hawaiian/Other Pacific Islanders do not meet standards for reliability or precision.

High School Students Who Engaged in Selected Weight Control Behaviors in Past 30 Days, by Sex, 2011

Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Includes diet pills, powders or liquids.

MENTAL HEALTH

In 2010, 8.0 percent of adolescents aged 12–17 years, or 1.9 million adolescents, experienced at least one major depressive episode (MDE), which is defined as having at least 2 weeks of a depressed mood or loss of interest or pleasure in daily activities, plus a majority of specific depression symptoms, such as altered sleeping patterns, fatigue, and feelings of worthlessness (data not shown).⁶⁸ Females were more likely than males to experience MDE (11.8 percent versus 4.4 percent). Occurrence of MDE increased with age, from 3.3 percent among children age 12 years to 10.9 and 10.3 percent

among children ages 16 and 17, respectively (data not shown).

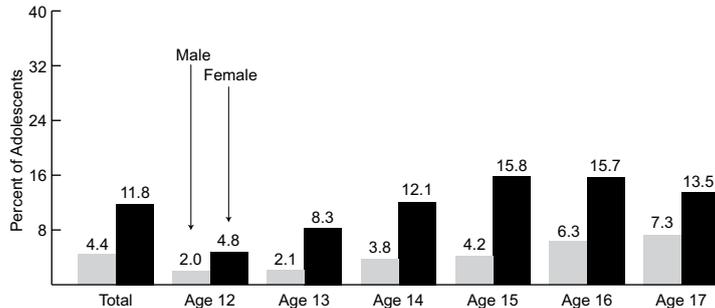
Among adolescents experiencing MDE in 2010, over two-thirds (1.3 million) also experienced severe impairment, defined by the degree to which activities and roles, such as completing chores at home, going to school or work, or maintaining close family relationships, are affected. MDE with severe impairment was more common among older adolescents and females (data not shown).

In 2010, adolescents aged 12 to 17 with past-year MDE were more likely than those without MDE to have used illicit drugs in the past year

(37.2 compared to 17.8 percent). Adolescents with past-year MDE were also more likely to report daily cigarette and heavy alcohol use in the past month compared with those without past-year MDE. Among adolescents with past-year MDE who used illicit drugs, 25.3 percent reported using marijuana or hashish, and 17.0 percent reported non-medical use of psychotherapeutics such as pain relievers, tranquilizers, stimulants, and sedatives. Among adolescents who did not experience past-year MDE, the proportion who reported using these substances was 12.9 and 6.5 percent, respectively (data not shown).

Occurrence of Major Depressive Episode (MDE)* in the Past Year Among Adolescents Aged 12–17 Years, by Age and Sex, 2010

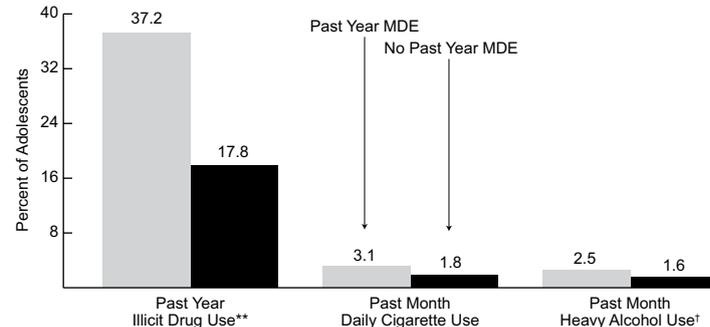
Source (II.20): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of pleasure in daily activities and had a majority of specific depression symptoms.

Substance Use Among Adolescents Aged 12–17 Years, by Past-Year Major Depressive Episode (MDE)*, 2010

Source (II.20): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of pleasure in daily activities and had a majority of specific depression symptoms. **Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. †Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

SUICIDE

In 2009, the latest year for which mortality data were available, suicide was the third leading cause of death among persons aged 15–24 years, resulting in over 4,300 deaths, for a rate of 10.2 deaths per 100,000 population. The most common methods used in suicides of adolescents and young adults include firearms (45.6 percent), suffocation (38.6 percent), and poisoning (8.0 percent).⁶⁹

In 2011, data from the Youth Risk Behavior Surveillance System showed that 15.8 percent of high school students had seriously consid-

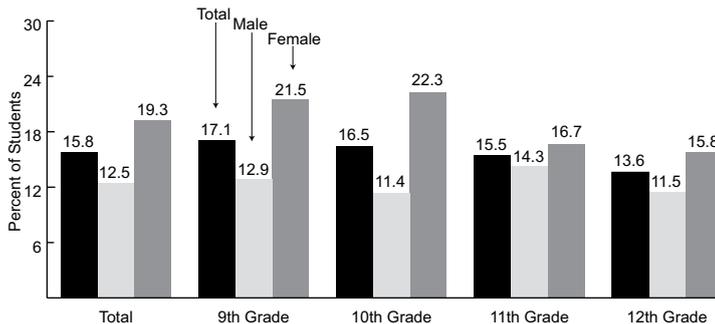
ered attempting suicide during the 12 months prior to the survey. Younger students, those in 9th and 10th grade, were more likely than the oldest students to consider suicide (17.1 and 16.5 percent, respectively versus 13.6 percent). Female students were more likely than males to have considered suicide at each grade level, with the exception of 11th grade, in which no significant difference by sex was observed.

In the same year, 7.8 percent of high school students reported having attempted suicide one or more times in the past 12 months, reflecting a significant increase since 2009 (6.3 percent).

Overall, females (9.8 percent) were more likely to report at least one suicide attempt than males (5.8 percent; data not shown). The proportion of students who reported having attempted suicide also varied by race/ethnicity. Non-Hispanic White students were less likely to report attempted suicide (6.2 percent) than students of all other racial and ethnic groups. Female students were significantly more likely to report attempted suicide among all racial and ethnic groups except non-Hispanic Blacks and students of more than one race (data not shown).

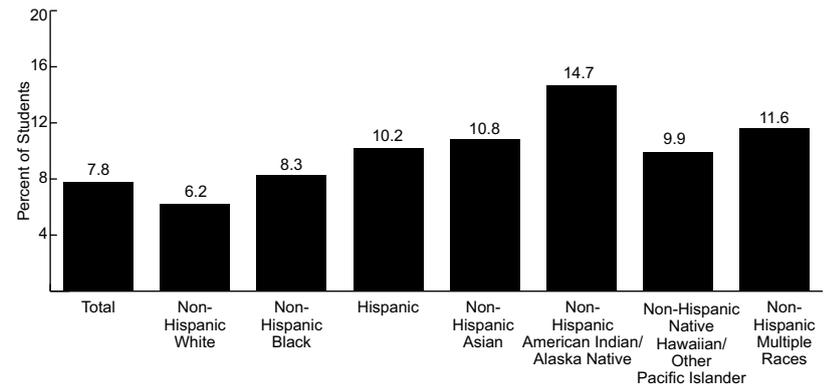
High School Students Who Considered Attempting Suicide in the Past 12 Months, by Grade Level and Sex, 2011

Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



High School Students Who Attempted Suicide One or More Times in the Past 12 Months, by Race/Ethnicity, 2011

Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



VIOLENCE

Physical violence among adolescents occurs in multiple forms and is a critical public health issue in the United States. Instances of violence include homicide, which was the second leading cause of death among all persons aged 10–24 years in 2009 (the latest year for which data are available).⁷⁰ For non-Hispanic Blacks aged 10–24 years, homicide was the leading cause of death, among Hispanics it was the second leading cause of death, and among non-Hispanic American Indians and Alaska Natives it was the third leading cause of death. Among both non-Hispanic Whites and Asian/Pacific Islanders it

was the fourth leading cause of death among individuals in this age group (data not shown).⁷⁰

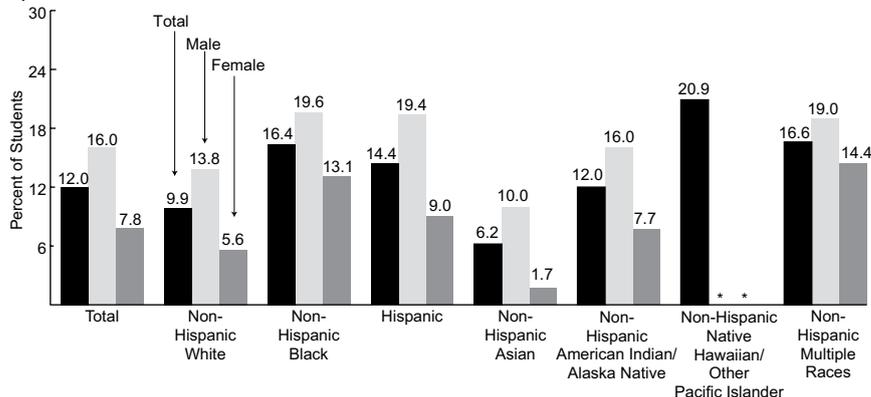
Data from the Youth Risk Behavior Surveillance System show that, in 2011, 12.0 percent of high school students reported being in a physical fight on school property during the preceding 12 months. Among males, 16.0 percent reported having been in a fight; this is more than twice the rate reported by females (7.8 percent). This disparity was most pronounced among non-Hispanic Whites, where males were almost three times as likely as females to have been in a fight (13.8 percent versus 5.6 percent), although significant sex differences were

observed across all racial/ethnic groups. Overall, non-Hispanic Asian students were least likely to report having been in a fight (6.2 percent) while over one-fifth of non-Hispanic Native Hawaiian or Other Pacific Islander students reported having been in a physical fight on school property in the past year.

Approximately 1 out of every 10 high school students reported that they were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend at least once in the past 12 months. The prevalence of dating violence was similar across grade levels and among males and females.

High School Students in a Physical Fight on School Property in the Past 12 Months, by Race/Ethnicity* and Sex, 2011

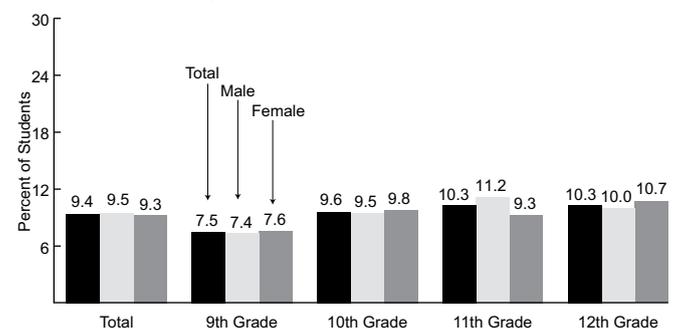
Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Sex-specific data for American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders do not meet standards for reliability or precision.

High School Students Experiencing Dating Violence* in the Past 12 Months, by Grade Level and Sex, 2011

Source (II.19): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Dating violence was defined as having been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend.

BULLYING

Bullying is defined as unwanted, aggressive behavior among school-aged children that may be repeated, or has the potential to be repeated, and involves a real or perceived imbalance of power. Making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose are all examples of bullying. There is no specific factor that puts children at risk of being bullied or bullying others, although some groups, such as lesbian, gay, bisexual, or transgendered (LGBT) youth, youth with disabilities, and socially isolated youth may be at higher risk.

Being bullied has been associated with a wide range of both short- and long-term emotional,

physical, and developmental consequences, including depression, anxiety, headaches, sleeping problems, stomach ailments, and decreased academic achievement. Children who bully are also more likely to engage in violent and risky behaviors, such as drug and alcohol use and early sexual activity. Even children who witness bullying can be negatively affected. Cyberbullying, or bullying that takes place using electronic technology, is different from other types of bullying in that it can happen at any time, messages and images can be posted anonymously and distributed quickly, and can be very difficult to delete after posting.⁷¹

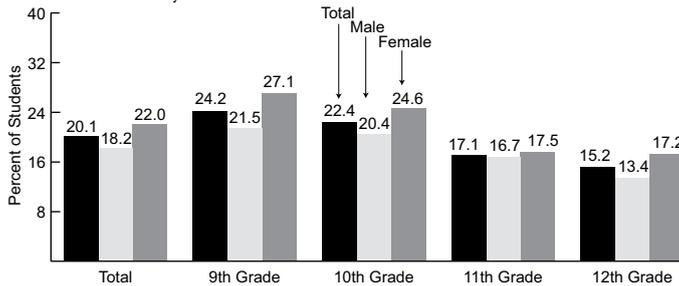
In 2011, 20.1 percent of high school students reported that they had been bullied on school property in the past year. The likelihood of a

child being bullied varied by a number of factors including sex and grade level. Females were more likely than males to have been bullied overall (22.0 percent versus 18.2 percent) while 24.2 percent of 9th graders reported being bullied compared to 15.2 percent of 12th graders.

Approximately one in six (16.2 percent) of high school students reported having been electronically bullied through email, chat rooms, instant messaging, Web sites or texting in the prior 12 months. Females were approximately twice as likely as males to have been electronically bullied at all grade levels (data not shown). Females were also more likely than males to have been electronically bullied across all racial and ethnic groups for whom race- and sex-specific data are available.

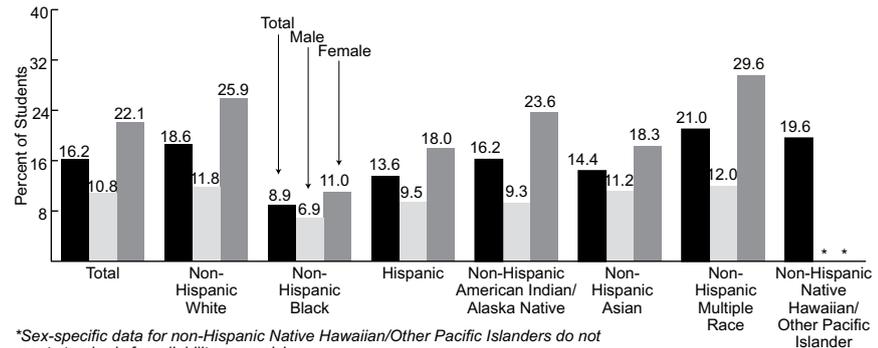
High School Students Who Were Bullied on School Property in the Past Year, by Sex and Grade, 2011

Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



High School Students Who Were Electronically Bullied in the Past Year, by Sex and Race/Ethnicity, 2011

Source (II.19): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



*Sex-specific data for non-Hispanic Native Hawaiian/Other Pacific Islanders do not meet standards for reliability or precision.

CIGARETTE SMOKING

In 2012, a report by the Surgeon General found that the majority of cigarette use begins in adolescence or young adulthood and reported that, “of every three young smokers, only one will quit, and one of those remaining smokers will die from tobacco-related causes.”⁷²

The percent of teens who report smoking in the past month began a rapid increase in the early 1990s, with the rates among 8th and 10th grade students reaching a peak in 1996 (at 21.0 and 30.4 percent, respectively), and the rate among 12th grade students peaking a year later (36.5 percent). After years of steady

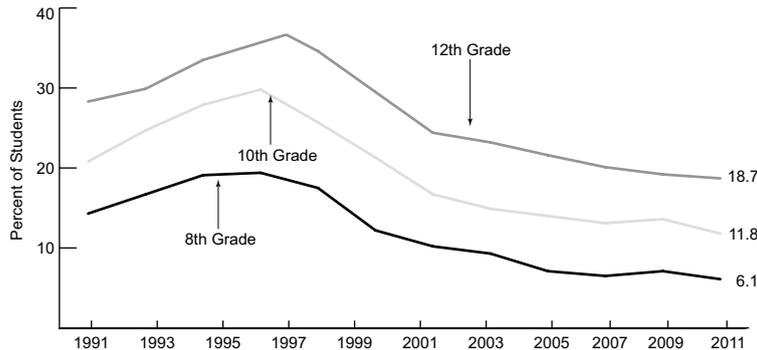
progress, declines in the use of cigarettes by adolescents and young adults have decelerated. In 2009, cigarette smoking among adolescents decreased to 12.7 percent, according to the annual Monitoring the Future study.⁷³ Between 2009 and 2010, the overall percentage of high school students who reported smoking cigarettes in the past 30 days rose from 12.7 percent in 2009 to 12.8 percent, but this change was not statistically significant. In 2011, declines in past-month smoking occurred among students in all three grades to 6.1 percent of 8th, 11.8 percent of 10th and 18.7 percent of 12th grade students. The decline between 2010 and 2011 was statis-

tically significant for 10th grade students only.

Despite a population-wide decline, certain subgroups of adolescents remain significantly more likely to smoke than their peers. Students who plan to complete a four-year college education are less than half as likely to smoke than students who either do not plan to attend college or plan to attend college for less than four years. This difference exists at each grade level. With regard to race and ethnicity, non-Hispanic White students are the most likely to report smoking in the past month, followed by Hispanic students (data not shown).

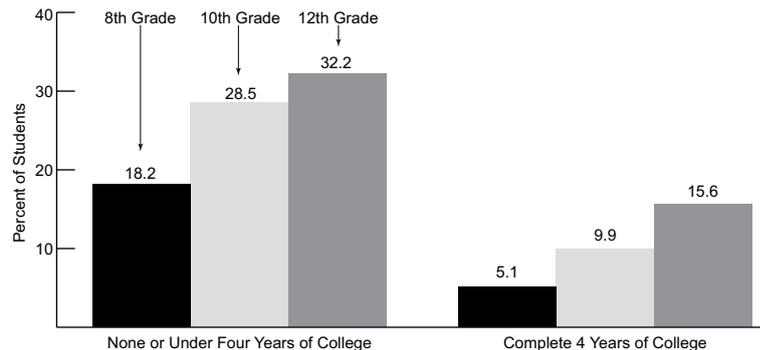
Cigarette Use Among Students in the Past 30 Days, by Grade, 1991–2011

Source (II.21): National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Study



Cigarette Use Among Students in the Past 30 Days, by College Plans, 2010–2011

Source (II.21): National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Study



SUBSTANCE ABUSE

In 2010, the percent of adolescents aged 12–17 years who reported using illicit drugs in the past month was 10.1, similar to the 2009 estimate (10.0). Illicit drug use varied by age, with 4.0 percent of youth aged 12–13 years reporting drug use in the past month, compared to 9.3 percent of youth aged 14–15 years and 16.6 percent of youth aged 16–17 years (data not shown). There was also variation by race/ethnicity, with rates ranging from 4.1 percent among non-Hispanic Asian youth to 12.7 percent among non-Hispanic American Indian/Alaska Native youth. Rates for non-Hispanic White, non-Hispanic Black, and Hispanic youth were 9.7 percent, 10.8 percent, and 11.8 percent, respectively (data not shown).

Marijuana is consistently the most commonly used illicit drug among adolescents overall, with 7.4 percent reporting past-month use in 2010. This was followed by nonmedical use of prescription-type psychotherapeutics, such as pain relievers, tranquilizers, stimulants, and sedatives (3.0 percent). Differences by age were observed, however, with younger adolescents aged 12–13 years being more likely to report non-medical use of psychotherapeutic drugs.

Illicit drug use is associated with other health risk behaviors. In 2010, 52.9 percent of adolescents who reported cigarette use in the past month also reported illicit drug use,

compared to only 6.2 percent of adolescents who did not report smoking. Adolescents who reported alcohol use in the past month were also more likely to use illicit drugs than adolescents who did not report alcohol use: 70.6 percent of heavy drinkers (i.e., adolescents who consumed five or more drinks on the same occasion on each of 5 or more days in the past 30 days), also used illicit drugs.

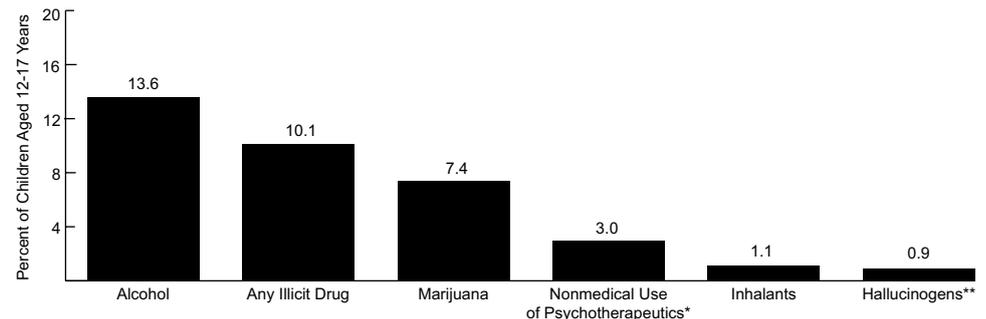
Alcohol continues to be the most commonly used drug among adolescents, with 13.6 percent reporting past-month use in 2010. The prevalence of alcohol use among males and females was similar: 13.7 and 13.5 percent, respectively). Greater variation was evident by race/ethnicity, with rates ranging from 4.8 percent among Asian youth to 14.9 percent of non-Hispanic White youth (data not shown).

In 2010, 30.1 percent of adolescents perceived smoking marijuana once a month to be a great risk, while 49.5 percent perceived the same risk regarding cocaine use. Smoking one or more packs of cigarettes a day was considered a great risk by 65.5 percent of adolescents. Drinking five or more drinks once or twice per week was considered a great risk by 40.8 percent of adolescents (data not shown).

While 14.3 percent of adolescents were approached by someone selling drugs in the past month, nearly 50 percent reported that marijuana would be fairly or very easy to obtain; 22.1 percent reported the same for crack, 19.0 percent for cocaine, 12.9 percent for LSD, and 11.6 percent for heroin (data not shown).

Past Month Drug Use Among Adolescents Aged 12-17 Years, by Drug Type, 2010

Source (II.22): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Includes non-medical use of pain relievers, sedatives, stimulants, and tranquilizers; does not include over-the-counter substances.

**Includes LSD, PCP, and Ecstasy.

ADOLESCENT MORTALITY

In 2010, the latest year for which data are available, there were 10,887 deaths among adolescents aged 15–19 years, representing a rate of 49.4 per 100,000.⁷⁴ The rate of adolescent mortality declined by 7.7 percent from the previous year and 26.4 percent from 2000. This decline may be largely attributable to decreases in unintentional injury,⁷⁵ which remains the leading cause of adolescent death, followed by homicide, suicide, cancer, and heart disease.

The mortality rate of adolescent males aged 15–19 was more than twice that of females in 2010 (69.6 versus 28.1 per 100,000, respectively). This disparity is largely due to higher rates of unintentional injury, homicide, and suicide

death among male adolescents. For example, homicide death rates were more than five times higher among males than females (14.0 versus 2.3 per 100,000). Homicide and suicide, when combined, account for almost as many deaths as unintentional injuries among male adolescents.

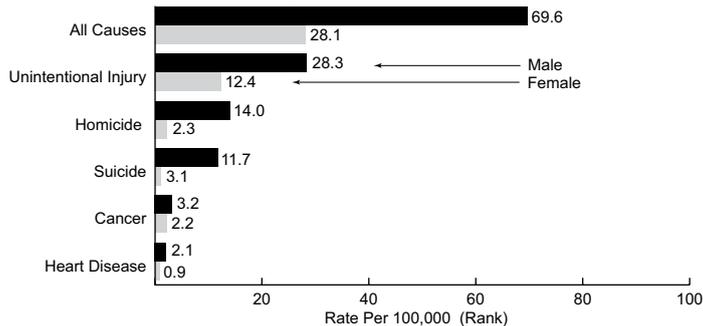
Racial and ethnic disparities also exist, with non-Hispanic American Indian/Alaska Native adolescents experiencing the highest rate of mortality among both males and females (138.6 and 57.6 per 100,000, respectively). Non-Hispanic Black males had the second highest rate of adolescent mortality (108.0 per 100,000) while non-Hispanic Asian/Pacific Islander females had the lowest rate (16.0 per 100,000). Unintentional injury was the leading cause of

death among male and female adolescents of all racial/ethnic groups, except non-Hispanic Black males, for whom homicide was the leading cause of death (data not shown).

The primary cause of unintentional injury death was motor vehicle crashes (63.8 percent), followed by poisoning (16.4 percent) which is the only unintentional injury mechanism to increase over the past decade.^{74,75} Poisoning includes prescription drug overdoses. Homicide deaths to adolescents were predominantly attributable to firearms (84.8 percent) while both firearms and suffocation were leading mechanisms of suicide death (40.3 and 45.3 percent, respectively; data not shown).⁷⁴

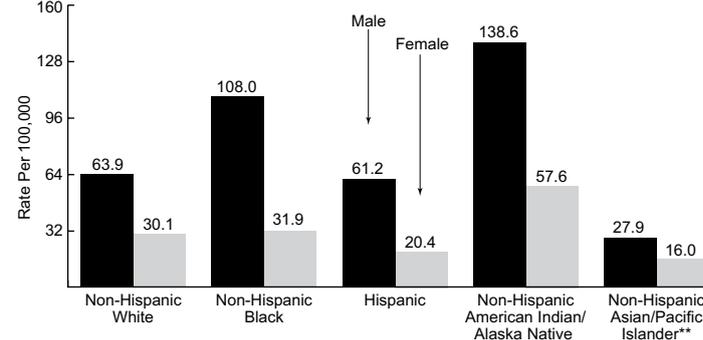
Mortality Rates Among Adolescents Aged 15–19 Years, by Selected Leading Cause and Sex, 2010

Source (II.23): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Mortality Rates Among Adolescents Aged 15–19 Years, by Race/Ethnicity* and Sex, 2010

Source (II.23): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Multiple-race data were bridged to single-race categories **Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The National Survey of Children with Special Health Care Needs (NS-CSHCN) asks parents about the types of chronic health conditions experienced by their children and how these conditions impact both the child and their family. These chronic conditions include developmental difficulties such as Down Syndrome and Autism Spectrum Disorder, seizure disorders such as epilepsy, mental health disorders such as depression and anxiety, and other conditions which have lasted, or are expected to last, 12 or more months. Among CSCHN, the conditions (from a list of 20 specific conditions) that children are most commonly reported to

have are allergies, asthma, ADD/ADHD, and developmental delay. Co-morbidities are common, as more than half of all CSHCN experience more than one chronic condition. In the 2009–10 NS-CSHCN, 28.0 percent of all CSHCN reported 2 conditions, while an additional 29.1 percent of CSHCN reported 3 or more conditions.

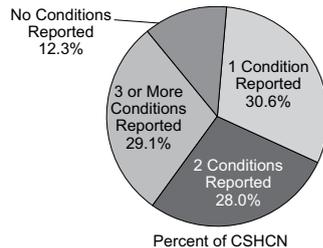
The impact of these conditions on the child varies by a number of factors. In general, CSHCN are as likely to participate in organized activities, volunteer and work for pay as those children without special health care needs; however, children with functional limitations experience additional barriers to participation.⁷⁶ The parents of over one-third of CSHCN reported

that in the past 12 months their child's condition never affected the child's ability to do the things that other children could do. A consistent barrier, where the condition always limited the child, was reported for 15.3 percent of CSHCN.

CSCHN who only require prescription medication to care for their condition are the least likely to experience a great deal of difficulty doing the things that other children can do (5.1 percent) as compared to children who require additional services (13.6 percent) or who have a functional limitation (40.9 percent). Only 10.7 percent of CSHCN who have a functional limitation experience "very little" difficulty in participation.

Number of Health Conditions* Reported for CSHCN, 2009–10

Source (II.24): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children with Special Health Care Needs



*Of 20 addressed in the survey. Because CSHCN status is determined by the presence of health-related impacts rather than a specific diagnosis, children may have a special health care need without having been diagnosed with one of the 20 conditions parents were asked about on the survey.

Degree to Which Special Health Care Need Affects the Child's Ability to Do Things, by Type of Special Health Care Need, 2009–10

Source (II.24): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children with Special Health Care Needs

