EXECUTIVE SUMMARY

HEALTHY KIDS
COLORADO SURVEY

2017
Prepared by the Colorado Department of Public Health and Environment (CDPHE) in partnership with Colorado Department of Education (CDE), Colorado Department of Human Services (CDHS), Colorado Department of Public Safety (CDPS) and the Colorado School of Public Health, University of Colorado Anschutz Medical Campus.
The Healthy Kids Colorado Survey, (HKCS) is the state’s only comprehensive survey on the health and well-being of young people. In 2017, the survey sampled approximately 56,000 youth from 190 randomly selected middle and high schools statewide.

The voluntary, biennial survey collects a wide range of health and behavioral information that helps public, private and community organizations better understand the youth they serve and support them in making healthy choices.

The State launched the biennial survey in 2013 as a unified effort to reduce the burden on schools and meet the needs of multiple public and private organizations seeking state and regional youth health and behavioral data.

Public and private organizations use this survey’s state and regional health data to identify trends and enhance school- and community-based programs that improve the health and well-being of young people.

This executive summary highlights select measures. Complete data are available on the HKCS website, www.healthykidscolo.org. There are more than 160 high school questions across two survey modules. CDPHE will continue to examine the data and release additional topic area reports throughout the year.

The data include, but are not limited to, weight, nutrition, physical activity, suicide, bullying, mental health, tobacco, alcohol, marijuana, drugs, sexual health (high school only), school and community engagement, and access to trusted adults. The data also reflect youth attitudes and perceptions that impact their health and examine what factors can influence a student to make healthy choices.

Results include comparisons by demographic information, including sex, race/ethnicity, sexual orientation and gender identity, among others.

The results highlight the health behavior disparities based on race and ethnicity. Upon reviewing the results of the 2017 HKCS, we would be remiss in our responsibility to statewide youth health to ignore that American Indian youth report the highest rates of many health issues, including obesity, e-cigarette use, experience with electronic bullying, suicide attempts, and hunger. These behaviors not only affect a youth’s current health and well-being, but also a youth’s ongoing development and opportunity to lead a happy and healthy life into adulthood.

Generations-long social, economic and environmental inequities result in adverse health outcomes, a reality too well-known among American Indians in the state. These inequities affect communities differently and have a greater influence on health outcomes than individual choices or one’s ability to access health care.

Although American Indian youth make up 1 percent of youth in the state, they disproportionately face critical challenges that negatively impact their health. These challenges include poverty and reduced access to quality education. In this Executive Summary, we will not only outline health disparities faced by American Indian youth but also contextualize these disparities by showing how and where youth live, learn, work and play can greatly impact their health and access to healthy options. This also is called the social determinants of health and in looking at health in this context, we can help paint a clearer picture of why these disparities exist.

The American Indian youth surveyed in the 2017 HKCS represent youth living on reservations and in urban settings. The examples of social determinants of health are provided for youth living on reservations, but we intend to add questions to the 2019 HKCS that will allow us to determine the percentage of youth living on reservations and living in urban settings so that we can learn more about the overall health of American Indian youth in both settings. CDPHE encourages
communities, schools, youth serving agencies, funders and public health researchers to use the 2017 health behavior results of American Indian youth as a launching pad to learn more about the American Indian youth they serve and how to support positive impacts on their health and futures.

If we reduce health disparities through policies, practices and organizational systems we can help improve opportunities for all Coloradans. From a systems-level approach, and given the history of American Indians in Colorado, if we, as public health practitioners, address the public health needs of youth experiencing the highest disparities, then we address the public health needs of all youth in our state.

SURVEY PARTICIPANTS AND RESPONSE RATES

Youth from a random sample of selected schools and randomly selected classrooms within those schools volunteer to complete the surveys. Researchers aggregate data to maintain anonymity and protect student confidentiality. HKCS suppresses the following estimates: 0 percent, 100 percent, if fewer than 30 youth answer the question, or if fewer than three responded “Yes” to the question. HKCS weighs the results to represent student enrollment in Colorado public middle and high schools.

HKCS and other sample-based surveys use weighting to show how samples represent the larger population. The weights account for sampling design, school and student nonparticipation and nonresponse, and discrepancies in grade, sex and ethnicity between the sample and the population.

Overall response rate (RR) is the product of the school participation rate and the student response rate:

\[
RR = \frac{Number\ of\ participating\ schools}{Number\ of\ selected\ schools} \times \frac{Number\ of\ completed\ student\ surveys}{Number\ of\ youth\ enrolled\ in\ selected\ classes}
\]

METHODS

This report highlights indicators in each of the main domains of the HKCS. The figures and text present the prevalence estimates, which is the proportion of students reporting a behavior. Figures present the 95% confidence intervals of estimates.

Statistical tests were conducted to evaluate statistically significant differences between the health outcomes by demographic characteristics (gender, grade, race/ethnicity, sexual orientation and gender identity). The race/ethnicity groups presented in this report are as follows: non-Hispanic white (“White”), non-Hispanic American Indian or Alaska Native (“American Indian”), non-Hispanic Asian, non-Hispanic Black or African American (“African American”), non-Hispanic Native Hawaiian or Other Pacific Island (“Pacific Islander”), Hispanic or Latino and White (“Hispanic”), and any combination of Hispanic and a racial group other than white (“multiracial”). Statistical comparisons were also conducted for sexual orientation and gender identity, which are reported in the text but not shown in figures. Sexual orientation was dichotomized, where lesbian/gay, bisexual, and “not sure” were combined to make the “LGB” variable, which was compared to heterosexual/straight. Gender identity was also dichotomized, where transgender and “questioning” were combined to create a “transgender” category which was compared to cisgender.

Differences between groups were evaluated using Rao-Scott chi-squared tests and logistic regression incorporating complex survey design. An alpha level of .05 was used to determine statistical significance, where a Dunnett’s test was used to correct for multiple pairwise comparisons. For within grade comparisons, all grades were compared to 9th grade. For race/ethnicity, all race/ethnic groups were compared to white students. For gender, males were compared to females. Differences between state and national estimates are determined by non-overlapping confidence intervals.
DEMOGRAPHICS

Overall, 51 percent of youth are female, 49 percent are male. When asked about gender identity, 95.7 percent are cisgender, 1.1 percent are transgender, 1.3 percent are unsure of their gender identity and, 1.6 percent report they did not understand the question. The race/ethnicity of youth are 57 percent White, 30 percent Hispanic, 5 percent African American, 4 percent Asian, 4 percent Multiracial, 1 percent American Indian, and <1 percent Pacific Islander. When asked about sexual orientation, 7.9 percent identified as bisexual, 4.6 percent chose “not sure”, and 2.4 percent of youth identified as gay or lesbian.

RACE/ETHNICITY:

- 56.6% White
- 30.4% Hispanic
- 4.5% African American
- 3.8% Multiracial
- 3.7% Asian
- 0.7% American Indian
- 0.3% Pacific Islander

GENDER IDENTITY:

- 97.5% Cisgender
- 1.4% Questioning
- 1.1% Transgender

SEX:

- 51.1% Female
- 48.9% Male

SEXUAL ORIENTATION:

- 85.1% Heterosexual
- 2.4% Gay or Lesbian
- 7.9% Bisexual
- 4.6% Not sure
Weight, Nutrition, and Physical Activity

RESULTS

HKCS measures a variety of indicators related to weight, nutrition and physical activity. The figure on the next page presents the proportion of youth categorized as obese based on their self-reported height and weight at the time of the survey.

Colorado youth are less likely to be obese compared to nationally (9.6 percent Colorado vs. 14.8 percent national). In Colorado, males were more likely than females to be obese (12.2 percent male vs. 7.0 percent female). All other race/ethnicity groups were more likely to be obese compared to White youth, except for Asian youth who were less likely to be obese. There are no significant differences in obesity by grade. Transgender and LGB youth were more likely to be obese than their cisgender and heterosexual peers.

American Indian youth obesity rates are the highest when compared to their peers by race and ethnicity, with double the statewide average (18.7 percent vs. 9.6 percent Colorado).

American Indian youth living on the Ute Mountain Ute reservation have limited access to healthy and safe spaces for active lifestyles. The Ute Mountain Ute Reservation consists of 553,008 acres of land with a total population of 1,087. There is just one park and one recreation center. In a Housing and Open Space Masterplan for the Ute Mountain Ute Tribe, residents reported incomplete sidewalks, street lights available in a short stretch of road near the highway, and “park spaces... in scattered patches that do not relate to one another.” These conditions create significant barriers for American Indian youth on the Ute Mountain Ute Reservation to lead active lifestyles, which contributes to greater rates of obesity.

As compared to national estimates, Colorado youth are more likely to be physically active and less likely to be sedentary (51.6 percent Colorado vs. 46.5 percent national). The prevalence of daily soda consumption in Colorado is not significantly different than nationally (as assessed by overlapping 95 percent confidence intervals).

Conditions like obesity are very much affected and determined by social factors such as the built environment. The built environment is the layout and design of a community’s buildings, streets, sidewalks and infrastructure. Studies show that the built environment, shaped through land use and transportation planning, policies and practices, can impact physical activity.


2 Ibid.
OBESITY

Defined as at or above the 95th percentile for body mass index.

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CONDITIONS LIKE OBESITY ARE VERY MUCH AFFECTED AND DETERMINED BY SOCIAL FACTORS SUCH AS THE BUILT ENVIRONMENT.

PHYSICAL ACTIVITY AND NUTRITION

‘Physical Activity’ defined as at least 1 hour per day for at least 5 days per week
‘Video/Computer Screen Time’ defined as at least 3 hours per day
‘Soda Consumption’ defined as at least 1 soda in the past 7 days
Tobacco Use (E-Cigarettes)

RESULTS

Both nationally and in Colorado, youth cigarette use has been declining in recent years. Colorado has a significantly higher prevalence of current (past 30 days) e-cigarette use (electronic vapor product use) compared to nationally (27.0 percent Colorado vs. 13.2 percent national). Males are more likely to have used e-cigarettes in the past 30 days than females and there is a higher prevalence of use in the older grades (10th, 11th and 12th grades).

African American, Asian and Hispanic youth reported significantly lower prevalence of current e-cigarette use compared to White youth. American Indian and Pacific Islander youth reported a higher prevalence of current e-cigarette use compared to White youth. Transgender and LGB youth report a higher prevalence of current e-cigarette use compared to cisgender and heterosexual youth (not shown).

Youth across racial and ethnic identities in Colorado report an elevated rate of e-cigarette use when compared to national rates. However, American Indian youth reported more than twice the national rate of e-cigarette use (30.5 percent vs. 13.2 percent national), only second to Pacific Islander youth (33.3 percent vs. 13.2 percent national). American Indian youth make up a small percentage of Colorado’s population (1 percent) and Pacific Islander youth make up an even smaller percentage of the population (less than 1 percent). Despite these small numbers, both groups show the highest rates of e-cigarette use compared to their peers by race and ethnicity.

CURRENT E-CIGARETTE USE (PAST 30 DAYS)

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Communities with high rates of poverty often have a higher concentration of retail outlets that sell alcohol, tobacco and fast food. Approximately 23.4 percent of American Indian residents and 12.9 percent of Pacific Islander residents of Colorado report living in poverty compared to 10.1 percent of White residents. Research shows that 90 percent of tobacco users start using before age 18. It is critical to educate youth on the risks of tobacco use to prevent continued use into adulthood.

The portion of youth who have ever tried e-cigarettes and who use cigarettes, did not significantly differ between Colorado and the nation. Among Colorado youth, e-cigarettes are the second highest substance that youth have tried among all substances. Alcohol is the most tried substance among youth.

90% of tobacco users start using before age 18.
Alcohol Use

RESULTS

Among youth in Colorado, 28.7 percent reported drinking alcohol at least once in the past 30 days. Females are more likely than males to currently use alcohol (past 30 days) and there is a higher prevalence of use in the older grades (10th, 11th and 12th grades). Asian and African American youth are less likely to drink alcohol than White youth. Pacific Islander youth are more likely to drink alcohol than White youth. Transgender and LGB youth are more likely to drink alcohol than cisgender and heterosexual youth (not shown).

Colorado does not significantly differ from the national average for current (past 30 days) alcohol use, lifetime alcohol use or having ridden in a car with someone who had been drinking (past 30 days). Colorado youth were more likely to report binge drinking (past 30 days) than their peers nationwide.

CURRENT ALCOHOL USE (PAST 30 DAYS)

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ALCOHOL USE

- **Lifetime (any) alcohol consumption**
  - National: 60.4%
  - Colorado: 59.0%

- **Current (past 30 days) binge drinking**
  - National: 13.5%
  - Colorado: 16.0%

- **Rode in car when the driver had been drinking (past 30 days)**
  - National: 16.5%
  - Colorado: 15.2%
Marijuana Use

RESULTS

Among youth in Colorado, 19.4 percent reported using marijuana at least once in the past 30 days. There was not a significant difference by gender. There was an increasing prevalence of use in older grades compared to 9th grade. Asian youth were less likely than White youth to currently use marijuana. Hispanic, Multiracial and Pacific Islander youth were more likely to use marijuana than White youth. Transgender and LGB youth are more likely to use marijuana than cisgender and heterosexual youth (not shown).

Colorado does not significantly differ from the national average in lifetime, current (past 30 day), or early (before age 13) marijuana use.

CURRENT MARIJUANA USE (PAST 30 DAYS)

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YOUNG PEOPLE WITH TRUSTED ADULTS IN THEIR LIFE ARE LESS LIKELY TO USE MARIJUANA

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<td><strong>Tried marijuana before 13 years old</strong></td>
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Prevalence (%) in 2017
OTHER SUBSTANCE USE

RESULTS

HKCS asks youth about the use of various illicit drugs, including cocaine, heroin, methamphetamines, ecstasy and sniffing glue. For the first time, the 2017 HKCS collected data on youth prescription pain medication use both with and without a prescription. This report highlights misuse of prescription pain drugs as the most common substance use behavior after tobacco, alcohol and marijuana. The prevalence of having ever taken prescription pain medication without a doctor’s prescription did not differ significantly between Colorado and the national average. However, special attention should be directed to substance use behavior among Pacific Islander youth, who use at twice the rate as the state average (25.4 percent vs. 12.4 percent Colorado).

Females are more likely to currently use alcohol (past 30 days), whereas males are more likely to currently use e-cigarettes, cigarettes or misuse prescription drugs (past 30 days). There was no gender difference in the prevalence of current marijuana use.

LIFETIME (ANY) PRESCRIPTION PAIN DRUG MISUSE

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CURRENT SUBSTANCE USE (PAST 30 DAYS)

BY GRADE

CURRENT SUBSTANCE USE (PAST 30 DAYS)

BY SEX

Healthy Kids Colorado Executive Summary
Bullying, Personal Safety and Violence

RESULTS

With the ever-presence of cell phones and social media, there is growing concern about emerging electronic forms of bullying (through email, text, chat rooms, messaging applications or websites). In Colorado, 14.9 percent of youth report they have been bullied electronically in the past 12 months. Females report significantly higher rates of having been bullied electronically than males. Older grades (11th and 12th) have significantly lower rates of bullying than 9th graders. LGB and transgender youth report approximately twice the prevalence of having been bullied electronically compared to heterosexual and cisgender youth (not shown).

Asian, African American and Hispanic youth report lower rates of having been bullied electronically compared to White youth. American Indian youth report the highest rates of electronic bullying (21.8 percent), followed by Pacific Islander youth (19.5 percent).

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LGB AND TRANSGENDER YOUTH REPORT APPROXIMATELY TWICE THE PREVALENCE OF HAVING BEEN BULLIED ELECTRONICALLY.
This is significantly higher than state and national rates (14.9 percent Colorado and national).

Colorado youth were significantly less likely to have been in a physical fight in the last 12 months compared to nationally (18.0 percent Colorado vs. 23.6 percent national). There were no significant differences in the prevalence of having been bullied, having been bullied electronically or having skipped school because of feeling unsafe (past 30 days) between Colorado and the national average.

Girls were more likely than boys to have been bullied at school or electronically in the past 12 months. They also have been more likely to have skipped school because they felt unsafe in the past month. Boys were more likely than girls to have been in a physical fight or have carried a weapon on school property in the past 30 days.
Mental Health

RESULTS

One of the leading causes of death for adolescents is suicide. This is true for youth in Colorado and nationally. Among youth in Colorado, 7.0 percent attempted suicide in the past 12 months, which was not significantly different from the national estimate (7.4 percent).

Females were more likely to have attempted suicide than males. LGB and transgender youth were more likely to have attempted suicide than heterosexual and cisgender youth (not shown) and there were no significant differences by grade. American Indian, Hispanic, Pacific Islander and Multiracial youth had a higher rate of suicide attempts compared to White youth and when compared to state and national rates.

American Indian youth not only report the highest rates of having attempted suicide (12.6 percent) when compared to their peers by race and ethnicity, but also report a rate that is almost double that of state and national estimates (7 percent Colorado, 7.4 percent national).

One explanation for these high rates could be related to housing and how stable housing impacts mental health. Research by The Bay Area Regional Health Inequalities Initiative (BARHII) shows that “affordable and quality housing is...
central to health” and that “housing insecurity, especially triggered by poverty, was associated with behavioral problems in children”. ³

A Ute Mountain Ute Reservation leadership report showed that the community has a housing shortage of 200 homes, resulting in overcrowding (or families “doubling up”), poor housing quality and housing instability.⁴ This same report revealed a loss of cultural knowledge, such as language and traditional practices and historical trauma among younger generations.

Historical trauma is defined by Maria Yellow Horse Brave Heart, PhD, as “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma”. American Indians have experienced centuries of trauma in their communities; the boarding school years being one example of these traumas. Historical trauma can negatively affect the mental health of communities for generations far removed from original trauma and can manifest itself as mental health issues, substance use and abuse, and suicidal ideations and attempts, to name a few.

The report also showed that youth said there was “a disconnect between youth and adults, but an affection and respect for elders”.⁵


⁵ Ibid

### FELT SAD FOR TWO OR MORE WEEKS IN A ROW (PAST 12 MONTHS)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>31.5%</td>
</tr>
<tr>
<td>Colorado</td>
<td>31.4%</td>
</tr>
<tr>
<td>9th grade</td>
<td>27.8%</td>
</tr>
<tr>
<td>10th grade</td>
<td>31.2%</td>
</tr>
<tr>
<td>11th grade</td>
<td>32.9%</td>
</tr>
<tr>
<td>12th grade</td>
<td>33.9%</td>
</tr>
<tr>
<td>American Indian</td>
<td>37.5%</td>
</tr>
<tr>
<td>Asian</td>
<td>29.8%</td>
</tr>
<tr>
<td>Black</td>
<td>27.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>35.2%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>38.3%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>29.3%</td>
</tr>
<tr>
<td>White</td>
<td>29.1%</td>
</tr>
<tr>
<td>Female</td>
<td>40.6%</td>
</tr>
<tr>
<td>Male</td>
<td>22.3%</td>
</tr>
</tbody>
</table>
Research shows that efforts focusing on connecting American Indian youth to cultural traditions, practices, and language can help younger generations heal and recover from historical trauma, helping to break this cycle. This can have a positive impact on the mental health of American Indian youth.

About a third of youth (31.4 percent in Colorado, 31.5 percent nationally) report feeling sad or hopeless. Identifying sad or depressed youth and linking them with care can help prevent suicide attempts and deaths.

Girls were more likely than boys to report poorer mental health, including having felt sad for two weeks or more, seriously considered suicide, made a suicide plan and attempted suicide in the past 12 months.

MENTAL HEALTH (PAST 12 MONTHS) BY SEX

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt sad for 2 or more weeks in a row</td>
<td>40.6%</td>
<td>22.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriously considered committing suicide</td>
<td>21.5%</td>
<td>12.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned about how to attempt suicide</td>
<td></td>
<td></td>
<td>15.9%</td>
<td>10.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>8.8%</td>
<td>5.2%</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Sexual Health

RESULTS

As compared nationally, youth in Colorado reported lower rates of sexual activity (sexual activity in the past three months) and were more likely than the national average to use birth control the last time they had sexual intercourse. There was no difference between Colorado and the national prevalence of youth who used alcohol or drugs before their last sexual activity.
Among youth in Colorado, 69.0 percent saw a doctor in the past 12 months for a check-up and 77.9 percent saw a dentist in the past 12 months. We know that regular check-ups with doctors and dentists can keep youth healthy and prevent serious health conditions from worsening. About 1 in 5 (20.8 percent) youth have been told by a doctor or nurse that they have asthma. Thirty-one percent (30.8 percent) of youth report they typically sleep eight or more hours a night. The American Association of Pediatrics’ (AAP) recommends 8.5 to 9.5 hours of sleep per night for adolescents.

Some youth have access to limited resources and experience an unstable home environment, which can impact many aspects of their health. Three percent of youth usually slept somewhere other than their parent or guardian’s home in the past 30 days. Fourteen percent (14.1 percent) of youth report they went hungry because there wasn’t food at home. Pacific Islander (34 percent) and American Indian (30 percent) youth report the highest rates of having gone hungry (past 30 days), followed by Asian (19.4 percent), Multiracial (18.4 percent), Hispanic (16.3 percent) and African-American (15.2 percent) youth. White (11.9 percent) youth report a lower rate of hunger than any other race.

Family income is a major factor in food insecurity for youth. The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. American Indian youth report almost double the state rate of going hungry because of lack of food in the home (30.1 percent vs. 14.1 percent Colorado). This is second only to Pacific Islander youth (34 percent).

### WENT HUNGRY FROM LACK OF FOOD (PAST 30 DAYS)

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>14.1%</td>
</tr>
<tr>
<td>9th grade</td>
<td>13.8%</td>
</tr>
<tr>
<td>10th grade</td>
<td>13.0%</td>
</tr>
<tr>
<td>11th grade</td>
<td>14.5%</td>
</tr>
<tr>
<td>12th grade</td>
<td>14.8%</td>
</tr>
<tr>
<td>American Indian</td>
<td>30.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>19.4%</td>
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<tr>
<td>Black</td>
<td>15.2%</td>
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<tr>
<td>Hispanic</td>
<td>16.3%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>18.4%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>34.0%</td>
</tr>
<tr>
<td>White</td>
<td>11.9%</td>
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</tbody>
</table>
Approximately 23.4 percent of American Indian residents and 12.9 percent Pacific Islander residents of Colorado report living in poverty in comparison to 10.1 percent of White residents. The Ute Mountain Ute Reservation reports an unemployment rate of 18 percent with 53 percent of households having children under the age of 18. Graduation rates on the reservation are 76 percent, with 4 percent going on to receive a Bachelor’s degree, and 1.2 percent a Professional Degree. Research shows that poor nutrition can make it harder for youth to move ahead in school and eventually graduate. This snapshot demonstrates how consistent access to healthy food in youth can have lasting effects into adulthood.

**14% OF YOUTH REPORT THEY WENT HUNGRY BECAUSE THERE WASN’T FOOD AT HOME.**

**CONNECTION TO SCHOOL AND TRUSTED ADULTS**

Adolescents spend a substantial portion of their day in a school. Feeling engaged and connected to school can protect youth from unhealthy decisions. Among surveyed youth, 68 percent say they participate in extracurricular activities or clubs at school. Females report a higher rate of participation in extracurricular activities than males and 12th graders report a


7 Ibid
lower rate of participation than 9th graders. Hispanic, Multiracial and African-American youth are less likely to participate in extracurricular activities than White youth. LGB and transgender youth report a lower rate of participation when compared to heterosexual or cisgender youth (not shown).

Conversely, 22.8 percent of youth report having skipped school in the last four weeks. This is higher among females than males, and higher among 10th, 11th and 12th grade youth than 9th grade youth. It was also higher among American Indian, African American, Hispanic and Multiracial youth than White youth. Skipping school (past 4 weeks) is also higher among LGB and transgender youth than heterosexual and cisgender students (not shown).
PUTTING DATA INTO ACTION

Notwithstanding the areas in which Colorado youth are making positive choices and avoiding risky behaviors, HKCS recognizes that gaps in youth health continue to exist between White youth and their peers of color and cisgender youth and their peers of other identities (LGB/T, and questioning). For this reason, there is a need to be ever mindful of health equity and health disparities when reviewing HKCS data and putting it into action.

We must identify and prioritize the greatest health disparities to ensure all young people in Colorado - including but not limited to young people of color, lesbian, gay, bisexual, transgender, queer, questioning, those living in poverty and/or experiencing homelessness - have access to caring supportive adults, safe neighborhoods, high-quality schools, inclusive community resources, culturally responsive physical and mental health providers and healthy foods.

In this executive summary we provide ways in which communities, schools, youth serving agencies, funders and public health researchers can dive deeper into the data by looking at how and where youth live, learn, work and play can impact their health, including the health disparities that American Indian youth experience. Putting the HKCS data to action can help us get closer to our goal of health equity for all Colorado youth.

Public and private organizations and individuals can use HKCS data to assess the health of young people in local communities across Colorado through the identification of health disparities and inequities. HKCS data can be used to:

- Identify trends and changes in healthy behaviors over time.
- Identify populations that are experiencing health disparities.
- Build community partnerships to collaboratively address community health issues, overcome barriers and measure success.
- Assess student health needs and school climate.
- Determine gaps in health services for young people in a specific school, district, region or statewide.
- Justify the use and measure the effectiveness of evidence-based interventions or promising health programs that improve health outcomes.
- Secure program funding for schools, community organizations and local public health agencies.
- Improve health equity among all young people.

The Healthy Kids Colorado Survey is a critical tool for our state’s decision-makers, communities, families and youth for obtaining evidence and data to clarify ongoing needs and opportunities. The HKCS can support communities all across Colorado as they encourage the growth of the healthiest youth in the nation.
NOTE

The Colorado Department of Public Health and Environment (CDPHE), Colorado Department of Education (CDE), Colorado Department of Human Services (CDHS) and Colorado Department of Public Safety (CDPS) support the HKCS. The Community, Epidemiology & Program Evaluation Group at the University of Colorado Anschutz Medical Campus administers the survey. The survey incorporates the Centers for Disease Control and Prevention’s (CDC) Youth Risk Behavior Surveillance System. HKCS results represent Colorado’s middle and high school populations statewide as well as regional estimates for each of the 21 health statistics regions for high school, unless otherwise noted. HKCS provides school and district level results to the respective school or district.

TO LEARN MORE, VISIT:

www.healthykidscolo.org

TO ACCESS TABLES OF RESULTS, TOPIC-SPECIFIC REPORTS, AND SURVEY METHODOLOGY INFORMATION, VISIT:

www.chd.dphe.state.co.us

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cdphe_healthykidscolorado@state.co.us