FYI — Kids
GSA / Child care
Assistance

FYI – Shirley
FYI Ann Olney

GSA News Release

U.S. General Services Administration, Washington, DC 20405

GSA #9651
March 16, 2000
Contact: Eleni Martin
(202) 501-1231

GSA Launches Plan To Assist Employees with Child Care Expenses

Washington, DC – In partnership with the American Federation of Government Employees (AFGE) and the National Federation of Federal Employees (NFFE), the U.S. General Services Administration is rolling out a tuition subsidy plan to help make child care more affordable for its lower-income employees. GSA offices nationwide are committed to supporting this subsidy for all qualified employees.

"Child care simply costs too much for many workers," said GSA Administrator David J. Barram. "Rates vary across the country, from about $3,800 to over $12,000 per year depending on the location of the center and the age of the child. We believe that in the long run, this program will help GSA employees to find a balance, to provide for quality early education for their children in healthy and safe environments, and to become better, more productive workers knowing that they can afford to put their children in good hands. I am proud that GSA is one of the first Federal agencies to seize this opportunity, for we see it as part of our continued commitment to work/life issues."

When Susan Clampitt, GSA's Associate Administrator for Child Care, surveyed the GSA workforce, she found that nearly 500 of GSA's lower-income employees indicated that they have young children in need of care. Under Office of Personnel Management regulations, GSA will be able to subsidize the cost of child care in licensed child care centers and family child care homes for children.

"I'm really enthused about this because child care subsidies will be a great benefit to many of the employees we represent," said Carl Yates, President of AFGE Council 236. "We worked in partnership with the agency in developing this initiative, and GSA should be commended for moving out so quickly on it."

"This is a good example of what the union and the agency can accomplish when they work together," said Jack Hanley, President of the NFFE Council of GSA Locals. "Affordable child care is an important issue for us, and we're hoping to use this success as a model for working cooperatively in the future on other issues affecting the GSA workforce."

Total family income will be the basis for determining eligibility for GSA's child care subsidy – $35,000 for a family with one dependent child and incremental increases of $3,000 for each additional dependent child, as the threshold for support. For example, a family with three dependent children, could earn up to $41,000 and still be eligible for the program. Parents will be required to provide proof of income and proof of enrollment of their children in a licensed child care facility.

Parents who meet the family income level threshold and who pay more than 10 percent in child care costs can apply for the subsidy. GSA will pay the difference between what parents pay for their children's child care and 10 percent of the total family income. Payments will be made directly to child care providers.

If a family with two children under six and a total family income of $36,000 is paying a total of $800 a month, or $9,600 a year, in child care expenses, then the subsidy would be $500 a month, or $6,000 a year. This represents the difference between the total child care cost ($9,600) and 10% of the total family income ($3,600). A payment of $500 (or 1/12 of $6,000) would be made each month directly to the licensed provider. The family would reduce their monthly out-of-pocket cost from $800 to $300.

The application form for GSA's child care subsidy is expected to be published in the Federal Register on March 17.

The legislation which makes this possible expires at the end of FY 2000, and in order for the subsidy program to be continued, the amendment must be re-authorized.

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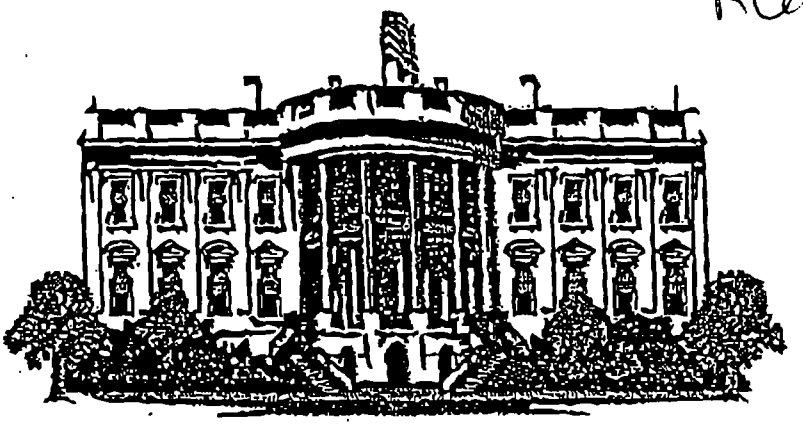
Ann - I have to go to a 7:30 pm appointment, but I am willing to come in early + write up a blurb for the weekly update if you want, call me at home (667-7779). You need to let Genie know if we are going to.

H+H

file: CDC Youth behavior Report



THE WHITE HOUSE

Domestic Policy Council

DATE: 6/8

FACSIMILE FOR: Heather Howard

62878

PHONE: ( ) - FAX: ( ) -

FACSIMILE FROM: Genie

65566

PHONE: ( ) - FAX: ( ) -

NUMBER OF PAGES (INCLUDING COVER): ____

① pres. release
② fact sheet
③ Q&As

[ ] FOR YOUR REVIEW
[✓] PER MY E-MAIL OR VOICE-MAIL MESSAGE TO YOU
[ ] PER YOUR REQUEST

COMMENTS: Here's YRBS → please look over & let us know ASAP if you plan to do weekly on whole report or not. If not, will do one focusing on tobacco results.

Thanks

RForbes@osophs.dhhs.gov (Ripley Forbes)
06/08/2000 11:32:09 AM

Record Type: Record

To: Eugenia Chough/OPD/EOP

cc:
Subject: FW: YRBSS

Content-Type: text/plain;

Apparently you were right. Here are both packages of the release.

_____ Forward Header _____
Subject: FW: YRBSS
Author: "Bailey; Linda" <lub4@cdc.gov> at INTERNET
Date: 6/8/00 11:18 AM

Ripley,

Here are the Q&As. Sorry we didn't get this to you yesterday; I was in meetings in ATL all day and didn't check email until this morning.

Let me know if you have any questions/concerns.

Linda

> ——Original Message——
> From: Grant, Llelwyn
> Sent: Wednesday, June 07, 2000 1:30 PM
> To: NCCD/OSH Managers; Warren, Wick C.; Stevens, Perry
> Subject: YRBSS
>
> DASH will be releasing their YRBSS report tomorrow, which will be
> embargoed until 4:00 p.m. FYI - Below are support documents, i.e., a
> press release, a fact sheet, and Q&A's, developed for the report. A note
> to our tobacco control partners is being developed and will be sent out
> first thing tomorrow morning. A draft hard copy of the report and draft
> tables have been provided to Dr. Eriksen, Linda Pedersen, and Wick.
> Anyone else interested in getting a draft copy of the report, please email
> or see me. The draft copies are not to be shared outside of OSH because
> of possible last minute revisions.
>
> Thanks all....Llelwyn
>
> <<yrbspress7.wpd>> <<yrbssfact4.wpd>> <<QsandAs2000.doc>>


- yrbspress7.wpd


- yrbssfact4.wpd


- QsandAs2000.doc

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

PRESS RELEASE

EMBARGOED FOR RELEASE
4 p.m. EDT

June 8, 2000
Contact: Katie Baer
National Center for Chronic Disease Prevention and Health Promotion
(770) 488-5131
CDC Media Relations
(404) 639-3286

Youth Risk Behavior Surveillance – United States, 1999

Since 1991, the prevalence of many injury-related behaviors and sexual behaviors have improved among high school students throughout the United States, according to the 1999 Youth Risk Behavior Surveillance System (YRBSS) report released today by the Centers for Disease Control and Prevention (CDC). Behaviors that show a significant decreasing trend during the past decade include the percentage of students who never or rarely wore seatbelts (37 percent decrease), carried a weapon (34 percent decrease), and ever had sexual intercourse (8 percent decrease). Further, the percentage of sexually active students who used a condom at last intercourse continued to increase (26 percent increase).

Nonetheless, too many high school students continue to practice behaviors that place them at risk for serious health problems. In the United States, nearly three fourths of all deaths among persons aged 10 to 24 result from only four causes: motor vehicle crashes (31 percent), other unintentional injuries (11 percent), homicide (18 percent), and suicide (12 percent). Results from the YRBSS suggest that many high school students practice behaviors that may increase their

likelihood of death from these causes — such as drinking and driving and carrying a weapon. Also, substantial health and social problems among youth result from unintended pregnancies and sexually transmitted diseases. Having sexual intercourse and not using a condom are two behaviors which increase risk for these health outcomes.

The YRBSS also measures risk behaviors such as physical inactivity, poor nutrition, and tobacco use because they are often initiated during adolescence and can result in chronic diseases, such as heart disease, cancer, and stroke. Two-thirds of all deaths among adults result from these diseases.

"There is reason to feel optimistic about many of the trends in risk behaviors among our young people," said CDC Director Jeffrey Koplan, M.D., M.P.H. "However, we have much left to do. Too many of our children are still engaging in activities that put them at risk for health problems now and into adulthood."

The Youth Risk Behavior Surveillance System monitors six areas of priority health-risk behaviors among youth, including behaviors that lead to intentional and unintentional injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, and physical activity. This report includes data for the nation, 33 states and 16 large cities.

The survey is administered every two years to scientifically selected samples of high school students throughout the United States. For the 1999 national YRBSS, 15,349 questionnaires were completed by students in grades 9-12. Parental permission was obtained, student participation was voluntary, and responses were anonymous. States could modify the YRBSS

questionnaire to meet their needs.

"It is important to monitor risk behaviors among young people so we can develop better prevention programs and policies," said Laura Kann, PhD, chief of the Surveillance and Evaluation Research Branch at CDC's Division of Adolescent and School Health. "This is the only surveillance system that monitors a wide range of health risk behaviors among adolescents at the national, state, and local levels."

Nationwide, half of students (50 percent) reported current alcohol use, one third (35 percent) reported current cigarette use, and one fourth (27 percent) reported current marijuana use. Half (50 percent) of students reported having had sexual intercourse. One third (36 percent) of students had participated in a physical fight and 17 percent had carried a weapon.

Nearly 1 in 10 high school students were overweight, and 16% were at risk of being overweight. Less than one quarter of high school students ate the recommended daily allowance of fruits and vegetables.

Some risk behaviors vary considerably among states, cities, and particular subgroups of students. For example, the percentage of high school students attending a physical education class daily varied ninefold, from 7 to 61 percent (median: 27 percent), across state surveys. Nationwide, 8 percent of students reported current smokeless tobacco use; however, among white male students, the rate was 19 percent.

For more information, visit the following Web site:

http://www.cdc.gov/mmwr/ (pick Surveillance Summaries, Vol. 49/No. SS-5 June 8, 2000)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Youth Risk Behavior Surveillance – United States 1999

EMBARGOED FOR RELEASE
4 p.m. EDT

June 8, 2000
Contact: Katie Baer
National Center for Chronic Disease Prevention and Health Promotion
(770) 488-5131
CDC Media Relations
(404) 639-3286

Too many high school students continue to practice behaviors that place them at risk for serious injury, sexually transmitted diseases, including HIV infection, and chronic diseases such as heart disease and cancer according to data released today from the 1999 Youth Risk Behavior Surveillance System (YRBSS) by the Centers for Disease Control and Prevention. The YRBSS is the most comprehensive source of data on the health risk behaviors of high school students. Today's report contains information about high school students nationwide, in 33 states, and 16 large cities.

Among high school students nationwide:

Behaviors that contribute to unintentional and intentional injuries
- 16% rarely or never wore a seat belt when riding in a car.
- 85% of students who had ridden a bicycle during the 12 months preceding the survey rarely or never wore a helmet.
- 38% were injured while playing sports during the 12 months preceding the survey.
- 33% rode with a driver during the 30 days preceding the survey who had been drinking alcohol.
- 17% carried a weapon during the 30 days preceding the survey.
- 36% were in a physical fight during the 12 months preceding the survey.
- 8% attempted suicide during the 12 months preceding the survey.

Tobacco Use
- 35% smoked cigarettes during the 30 days preceding the survey.
- 17% smoked cigarettes on 20 or more days during the 30 days preceding the survey.
- 8% used smokeless tobacco during the 30 days preceding the survey.

Alcohol and other drug use
- 50% had at least one drink of alcohol during the 30 days preceding the survey.
- 32% had 5 or more drinks of alcohol on at least one occasion during the 30 days preceding the survey.
- 27% used marijuana during the 30 days preceding the survey.
- 4% used cocaine during the 30 days preceding the survey.
- 15% used inhalants during their lifetime.
- 9% used methamphetamines during their lifetime.

Sexual behaviors
- 50% had sexual intercourse during their lifetime.
- 16% had sexual intercourse with 4 or more partners during their lifetime.

- 36% had sexual intercourse during the past 3 months.
- 58% of currently sexually active students used a condom during last intercourse.
- 16% of currently sexually active students used birth control pills before last sexual intercourse.

Dietary behaviors

- 10% were overweight (at or above the 95th percentile for body mass index by age and sex).
- 16% were at risk for becoming overweight (at or above the 85th percentile and below the 95th percentile for body mass index by age and sex).
- 24% ate 5 or more servings of fruits and vegetables during the 7 days preceding the survey.
- 5% took laxatives or vomited to lose weight during the 30 days preceding the survey.

Physical activity

- 65% did vigorous physical activity for at least 20 minutes on 3 or more of the 7 days preceding the survey.
- 27% did moderate physical activity for at least 30 minutes on 5 or more of the 7 days preceding the survey.
- 56% were enrolled in physical education class.
- 29% attended physical education class daily.

Behaviors that show a significant decreasing trend between 1991 or 1993 and 1999 are the percentage of students who never or rarely wore a bicycle helmet, never or rarely used seatbelts, rode with a driver who had been drinking alcohol, carried a gun, carried a weapon at school, participated in a physical fight, participated in a physical fight at school, ever had sexual intercourse, had sexual intercourse with 4+ partners, and attended physical education classes daily.

Behaviors that show a significant increasing trend between 1991 and 1999 are the percentage of students who reported lifetime marijuana use, current cocaine use, current condom use, receiving HIV prevention education, and participating in strengthening exercises.

Considerable variation in the prevalence of risk behaviors occurs from state to state. The following eight behaviors had a five-fold or greater variation among the states:

Behaviors that contribute to unintentional and intentional injuries

- Felt too unsafe to go to school – 2% to 16%

Tobacco, alcohol, and other drug use

- Smoked more than 10 cigarettes per day – 1% to 11%
- Current smokeless tobacco use – 2% to 18%
- Purchased cigarettes at a store – 7% to 38%
- Current cocaine use – 1% to 8%
- Smokeless tobacco use on school property – 1% to 11%

Sexual behaviors

- Initiated sexual intercourse before 13 years of age – 3% to 16%

Physical activity

- Attended physical education class daily – 6% to 61%

The report is available at http://www.cdc.gov/nccdphp/dash/yrbs/dataproducts.htm. Reporters can obtain printed copies from the CDC Press Office, 404-639-3286.

Youth Risk Behavior Surveillance – United States, 1999
Q's and A's

1. What is the Youth Risk Behavior Surveillance System?

The Youth Risk Behavior Surveillance System implemented by CDC is the only surveillance system to monitor a wide range of priority health risk behaviors among representative samples of youth at the national, state, and local levels. Since the system was implemented in 1990, the number of participating states and cities has nearly doubled – from 32 to 62 sites.

2. When will a report on the 1999 data be released?

The 1999 data will be released in a report on June 9, 2000.

3. How will the report be published?

As an MMWR Surveillance Summary.

4. What data will be included?

The report includes data from the 1999 national school-based Youth Risk Behavior Survey (YRBS). These data are representative of high school students from all 50 states and the District of Columbia. These data can be used to determine how health risk behaviors change over time among students nationwide. This report also includes data from separate YRBS's conducted in 1999 by education and health agencies in 33 states and 16 cities.

5. What topics will be included?

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

6. How will the report be disseminated?

Advance copies of the report will be sent 24 hours in advance to the state health departments and the state education agencies that have data in the report, the 16 local education agencies that have data in the report, national organizations (e.g., NASBE, CCSSO, NSBA, NNY), and federal agencies (e.g., ED, NICHD). In addition, the report will be sent to all subscribers of the MMWR and be made available on the Internet (as is done will all MMWRs).

Based on our experience with the 1997 data, we are expecting wide interest in this surveillance summary. The 1997 data were released in an MMWR surveillance summary

in August 1998. Since then we have distributed over 10,000 copies of that surveillance summary.

7. How will the data be used?

The national YRBS data will be used to monitor 15 national health objectives for 2010 and 3 of the 10 Leading Health Indicators.

State and local health and education agencies use these data to support and improve health-related policies and programs for youth. For example:

In Dallas, YRBSS data regarding lack of physical activity among high school students led to development of an after-school physical education program.

In Louisiana, YRBSS data were used to help obtain funding for the Governor's Commission on Teen Pregnancy Prevention.

In Tennessee, YRBSS data were used by state legislators to craft the Coordinated School Health Improvement Act.

In Wisconsin, YRBSS data were published in the state's medical journal to help education new physicians about adolescent health issues.

In Hawaii, YRBSS data were used as the basis for development of a new teaching guide for health education being used statewide.

In Montana, YRBSS data were used to help track state progress in reducing tobacco use.

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

The most important finding is that too many high school students in the U.S. engage in a variety of behaviors that place them at risk for serious health, education, and social problems today and in the future. It is critical that we address these risk behaviors now, since they are associated with the leading causes of mortality and morbidity in this country, including heart disease, cancer, and stroke.

9. What is the most encouraging news out of the 1999 YRBS?

The most encouraging news is that the prevalence of many injury-related and sexual behaviors has improved among high school students throughout the U.S.

10. What is new in the 1999 YRBSS?

The 1999 YRBSs included questions for the first time on height and weight (which allows calculation of body mass index), dating violence, use of heroin and methamphetamines, milk consumption, TV watching, and being injured while exercising.

11. Are health risk behaviors increasing or decreasing over time?

There has been a **decrease** from 1991 or 1993 to 1999 in the percentage of students who:

- Never or rarely wore a bicycle helmet
- Never or rarely used seatbelts
- Rode with a driver who had been drinking alcohol
- Carried a gun
- Carried a weapon at school
- Participated in a physical fight
- Participated in a physical fight at school
- Ever had sexual intercourse
- Had sexual intercourse before age 13 years
- Had sexual intercourse with ≥ 4 partners
- Used birth control pills
- Attended physical education class daily

There has been an **increase** from 1991 to 1999 in the percentage of students who:

- Ever used marijuana
- Used marijuana before age 13 years
- Used cocaine during the past month
- Used a condom at last intercourse
- Received HIV prevention education at school
- Participated in strengthening exercises

12. How do the tobacco, marijuana, and cocaine data in this report compare to data from other surveys?

National Youth Tobacco Survey (NYTS)

National YRBS data on tobacco use can be compared directly to data from another national survey – the National Youth Tobacco Survey (NYTS). YRBS and NYTS are both school-based surveys. The YRBS is conducted in the Spring among 9th – 12th grade students (approximate ages 14-17). The 1999 NYTS was conducted in the Fall among 6th –12th grade students; although the data reported are for 9th – 12th grade students. Although two different surveys will never produce exactly the same results even if a similar method and population are used, when YRBS and NYTS data are compared, the results are quite similar.

	1999 YRBS 9th – 12th grade students	1999 NYTS 9th – 12th grade students
Current cigarette use	25.3	28.4
Current smokeless tobacco use	7.8	6.6
Current cigar use	17.7	15.3

Monitoring the Future

National YRBS data on cigarette, marijuana, and cocaine use can be compared directly to data from another national survey – Monitoring the Future (MTF). YRBS and MTF are both school-based surveys of high school students. The YRBS is conducted among 9th – 12th grade students (approximately ages 14-17). MTF is conducted among 10th and 12th grade students (approximately ages 15 and 17). Though two different surveys will never produce exactly the same results even if a similar method and population are used, when YRBS and MTF data for 10th and 12th grade students are compared, the results are generally similar.

	1999 YRBS – 12th grade	1999 MTF – 12th grade
Current cigarette use	42.8	34.6
Current alcohol use	61.7	51.0
Current marijuana use	31.5	23.1
Current cocaine use	4.8	2.6

	1999 YRBS – 10th grade	1999 MTF – 10th grade
Current cigarette use	34.7	25.7
Current alcohol use	49.7	40.0
Current marijuana use	27.8	19.4
Current cocaine use	3.7	1.8

National Household Survey on Drug Abuse (NHSDA)

National YRBS data on cigarette, marijuana, and cocaine use is often compared with data from the National Household Survey on Drug Abuse (NHSDA). However, the surveys differ in several important ways. The NHSDA is a household-based survey conducted among 12-17 year olds. Because the NHSDA is conducted in the home and because the population sampled is much younger as compared to either the YRBS or MTF, prevalence estimates are lower than those from either school-based survey.

	1999 YRBS 9th – 12th grade students	1998 NHSDA 12-17 year olds
Current cigarette use	34.8	18.2
Current alcohol use	50.0	19.1
Current marijuana use	26.7	8.3
Current cocaine use	4.0	0.8

Although the prevalence estimates from the NHSDA are lower than those from YRBS, NYTS, and MTF, all four surveys show similar subgroup (i.e., gender, age, race/ethnicity) differences. The YRBS, MTF, and NHSDA show generally similar trends over time, reporting recent increases in current use of marijuana and cocaine and a leveling off or decrease in current use of cigarettes.

13. Does the national YRBS provide drug data that is already collected through other federally-funded national surveys?

While the NYTS, MTF, NHSDA, and YRBS provide similar information on only a small number of variables – current use of cigarettes, alcohol, marijuana, and cocaine – the YRBS is the only national survey that provides a more comprehensive assessment of health risk behaviors among youth. The comprehensive approach taken by the YRBS is critical since most adolescents at risk for one category of health risk (e.g., drug use) also practice other risk behaviors (e.g., unprotected sexual intercourse or weapon carrying). Without YRBS data it would not be possible to examine the interrelationship of health risk behaviors among youth or to plan comprehensive interventions that address more than a single problem. Furthermore, the YRBS has a state and local component allowing assessment of priority risk behaviors by state and city.

14. How does the report from the Urban Institute on adolescent's risk-taking behavior differ from the YRBSS report?

The Urban Institute report provides data on the prevalence of 10 risk behaviors of youth. The report looks at 1) how the prevalence of risk behaviors among high school students changed from 1991 to 1997, 2) what percentage of teens in grades 7 -12 engage in multiple risk behaviors, and 3) which extra-curricular activities (e.g., clubs, sports, work) multiple risk taking teens participate in.

To describe the prevalence of risk behaviors, the report used data from the 1991, 1993, 1995, and 1997 YRBSS. The results presented are consistent with previously published data. The Urban Institute report does not include the most recent 1999 YRBS data. The Urban Institute report also uses data from the national Survey of Adolescent Males (NSAM) and the National Longitudinal Study of Adolescent Health (Add Health) to look at involvement in multiple risk behaviors and at the association between multiple risk behaviors and participation in extra-curricular activities.

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

There is no simple solution. Youth need to be provided with the skills and motivation to avoid risky behaviors. Families, schools, community organizations, and youth themselves must work together to help address these problems. We think interventions implemented by these groups should be based on the best behavioral research available.

16. What is CDC doing to help reduce the prevalence of health risk behaviors among high school students?

CDC works with other federal agencies, national nongovernmental organizations, and state and local departments of education, health, and social services to plan and implement four basic strategies: a) identifying and monitoring critical health events and related school events, b) synthesizing and applying research to increase the effectiveness of interventions, c) enabling relevant constituencies to plan and implement interventions, and d) evaluating the impact of interventions over time.

CDC provide fiscal and technical assistance to every state and 18 local education agencies and national health and education organizations to assist schools in implementing effective HIV-prevention education for youth. CDC also provides fiscal and technical assistance to state departments of education and state departments of health in 15 states to work together to help local districts implement effective school health programs. In the future CDC hopes to provide this support to all states.

17. Did you see much variation among states? What are the highlights?

Considerable variation in the prevalence of risk behaviors occurs from state to state. The following 8 behaviors had a five-fold or greater variation among the states:

Behaviors that contribute to unintentional and intentional injuries
- Felt too unsafe to go to school – 1.9% to 16.4%

Tobacco, alcohol, and other drug use
- Smoked more than 10 cigarettes per day – 1.4% to 11.0%
- Current smokeless tobacco use – 2.2% to 18.2%
- Purchased cigarettes at a store – 7.1% to 37.8%
- Current cocaine use – 1.5% to 8.5%
- Smokeless tobacco use on school property – 1.5% to 10.7%

Sexual behaviors
- Initiated sexual intercourse before 13 years of age – 3.2% to 16.0%

Physical activity
- Attended physical education class daily – 6.5% to 61.1%

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

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

19. Why are the 1999 YRBS data being released through an MMWR Surveillance Summary?

Since 1990 when the Youth Risk Behavior Surveillance System was first implemented, the initial release of data has always been through the MMWR. This publication provides wide access to the data in a timely fashion. A series of articles on specific topics were published with the 1990 and 1991 data. Beginning with the 1993 data and continuing with the 1999 data, an MMWR Surveillance Summary has been used for the initial release of data. While this approach is not as conducive to media coverage as other approaches, it has allowed CDC to release YRBS data in a timely fashion on nearly every available variable from the national survey as well as from the state, territorial, and local surveys. The Surveillance Summary instantly becomes a comprehensive resource for national, state, and local health and education officials who are developing policies and planning programs for youth. This allows the Youth Risk Behavior Surveillance System to serve a unique role as a primary decision making tool for health and education officials nationwide. While the Youth Risk Behavior Surveillance System does not provide in-depth information on any topic, it is the only comprehensive source of data on the most important health risk behaviors impacting youth.