Vermont School Health Profiles
2016 Report

VERMONT
Department of Health

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Executive Summary

The School Health Profiles is conducted every other year to help education and health agencies at various levels monitor and assess characteristics of and trends in school health education; physical education and physical activity; school health policies related to human immunodeficiency virus (HIV), tobacco-use prevention, and nutrition; school-based health services; family engagement; community involvement; and school health coordination. The Profiles includes two separate questionnaires, one for principals and one for the lead health educator (LHE) at each middle and high school.

The Principal Questionnaire focuses on policies, practices related to prevention, services provided, and family and community involvement, while the Lead Health Educator Questionnaire focuses on course requirements, content covered, and professional development.

School Health Coordination

- Almost all schools (91%) have at least one person who oversees or coordinates school health safety programs and activities. Nearly eight in ten have at least one group such as a school health council or team that offers guidance on the development and coordination of policies and health-related activities at the school (78%) or supervisory union level (78%).

Health Services

- Nearly all schools identify and track students with chronic conditions such as asthma, diabetes, and food allergies that may require daily or emergency management (96%). More than eight out of ten schools (82%) provide students with referrals to community-based health centers if they have been identified with chronic conditions or are at risk for activity, diet, and weight-related chronic conditions.
- Three-quarters of schools have a cooperative or formal agreement with an outside agency to provide mental health treatment.
- A third of schools (35%) provide tobacco cessation services to students, faculty, and staff either through direct services at school or arrangements with providers not on school property. Two-thirds (64%) have a cooperative or formal agreement with an outside agency to provide assessment and treatment services off-school property to students known or suspected to have substance use issues.
- Less than one in ten schools provide direct sexual health services on school property. Overall, only 7% of schools provide condoms for students.

Health and Physical Education

- About two-thirds (67%) of lead health educators are certified, licensed, or endorsed by the state to teach health education.
- All Vermont high schools and most middle schools (83%) require at least some health education instruction, either in a required health education course or in another academic setting, more than half (54%) require students to take two or more required courses. About nine in ten schools (89%) require at least three physical education courses between 6th and 12th grades.
- Once students reach high school, participation in required health and physical education courses decreases significantly after 9th grade.

Executive Summary

Tobacco, Alcohol, and Drug Use Policies

- All schools in Vermont have tobacco, alcohol, and drug use policies.
- Most alcohol and drug use policies include providing education (95%), referrals to treatment (89%), counseling (91%), and discipline (96%).
- Two-thirds of schools have policies that mandate a "tobacco-free environment" at all times and in all locations. While more than 90% of school policies explicitly prohibit the use of cigarettes, smokeless tobacco, cigars, and pipes by all students, faculty/staff and visitors, only two-thirds specifically ban the use of electronic vapor products.

Physical Activity and Nutrition

- One in ten schools have a comprehensive school physical activity program (CSPAP).
- Nearly eight in ten assess the availability of physical activity opportunities in their school. Most offer opportunities for physical activity after school, either through interscholastic sports (94%) or intramural sports and physical activity clubs (84%), other opportunities during the day (84%) and physical activity breaks during school (82%). Less than half of schools offer physical activity before school (42%).
- Nearly six in ten (57%) schools have a joint use agreement to share use of facilities with their community.
- A supportive school nutrition environment includes multiple elements related to how schools provide students access to nutritious meals and snacks. More than nine in ten schools use attractive displays for fruits and vegetables (95%), put fruits and vegetables where they are easy to access (93%), and serve locally grown foods (92%). About three-quarters have a school garden (75%), do not sell less healthy foods and beverages (74%), or prohibit ads and promotions for candy, fast food, or soft drinks (73%).
- Less than half of schools have vending machines, school stores, or snack bars available for students to purchase snack foods or beverages food (46%), prohibit the sale of candy and baked goods for fundraisers (47%) or prohibit staff from giving students food or food coupons as a reward (35%).

Safe and Inclusive Environments

- Nearly all schools prohibit harassment based on a student's perceived or actual sexual orientation or gender identity, have a designated staff member to whom students can confidentially report student bullying and sexual harassment, and publicize policies, rules, regulations related to bullying and sexual harassment.
- Eight in ten schools identify "safe spaces" where LBGTQ youth can receive support from administrators, teachers, or other school staff, about half have student-led clubs (e.g. GSAs) aimed to create a safe, welcoming, and accepting school environment for all youth regardless of sexual orientation or gender identity.

Family and Community Engagement

- Most schools have special events, student clubs, and classroom lessons to increase school-community connectedness and to learn about people different from themselves. Seven in ten schools provide students opportunities to peer tutor other students (72%) and participate in service learning projects (70%). More than half have clubs that give students opportunities to learn about people different from them (54%), offer programs where family and community members serve as role models to students in programs such as Big Brother Big Sister (53%), or host special events such as a multicultural week or family night (58%).
- Over half of schools (54%) engage in at least four family engagement strategies such as: communicating with parents about school health services and programs; linking parents and families to community health services, providing parents and families with information; and engaging parents and families as school volunteers and in health education activities at home.
- Schools are most likely to use electronic, paper, or oral communication to inform parents about school health services and programs (91%), and link parents and families to health services in the community (83%).

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Background and Methodology

LHE's are typically appointed by the school's principal as the person most knowledgeable about health education at the school. This person could include the teacher most responsible for overseeing health education in the school. It could be the only health educator in a school, an educator shared among several schools, a school nurse, or most experienced health educator.

The School Health Profiles helps education and health agencies at various levels monitor and assess characteristics of and trends in school health education; physical education and physical activity; school health policies related to human immunodeficiency virus (HIV), tobacco-use prevention, and nutrition; school-based health services; family engagement; community involvement; and school health coordination.

Topics Included on the School Health Profiles Questionnaires	
Principal Questionnaire	**Lead Health Educator Questionnaire**
Bullying and sexual harassment policies	Health education course requirements
Physical education and physical activity	Content of health education and materials provided
Tobacco-use prevention policies	Collaboration
Nutrition-related policies and practices	Professional preparation
Health services	Professional development
Family and community involvement	

Background and Methodology

In Vermont, the School Health Profiles (SHP) has been administered biannually since 2006. From 2006 through 2014, the principal and lead health educator were sent a paper and pencil questionnaire to complete. In 2016, Vermont moved the survey to an online platform allowing principals and LHEs to complete the survey using a computer, tablet, or smartphone.

In 2016, all Vermont public schools that serve students in two or more grades 6 through 12 were invited to participate. Principals were notified by the Vermont Department of Health (VDH) about the SHP and were asked to designate the school's lead health education teacher or the person most knowledgeable about health education at their school. Beginning in February 2016, principals and LHEs were invited via email to complete the School Health Profiles. Each person received an individualized email with a link to access the Web-based questionnaire. Participation in the survey was confidential and voluntary; follow-up emails and telephone calls were used to encourage participation. Data collection was completed by the end of April 2016.

Of the 150 public schools containing any grades 6 through 12, one or both questionnaires were received from 97% of schools. After data cleaning and editing, usable questionnaires were received from principals in 91% of schools and from lead health education teachers in 89% of schools.

	Middle Schools[1]	Junior / Senior High Schools[2]	High Schools[3]	Total	Response Rate
Principals	79	32	25	136	91%
Lead Health Educators	76	32	26	134	89%

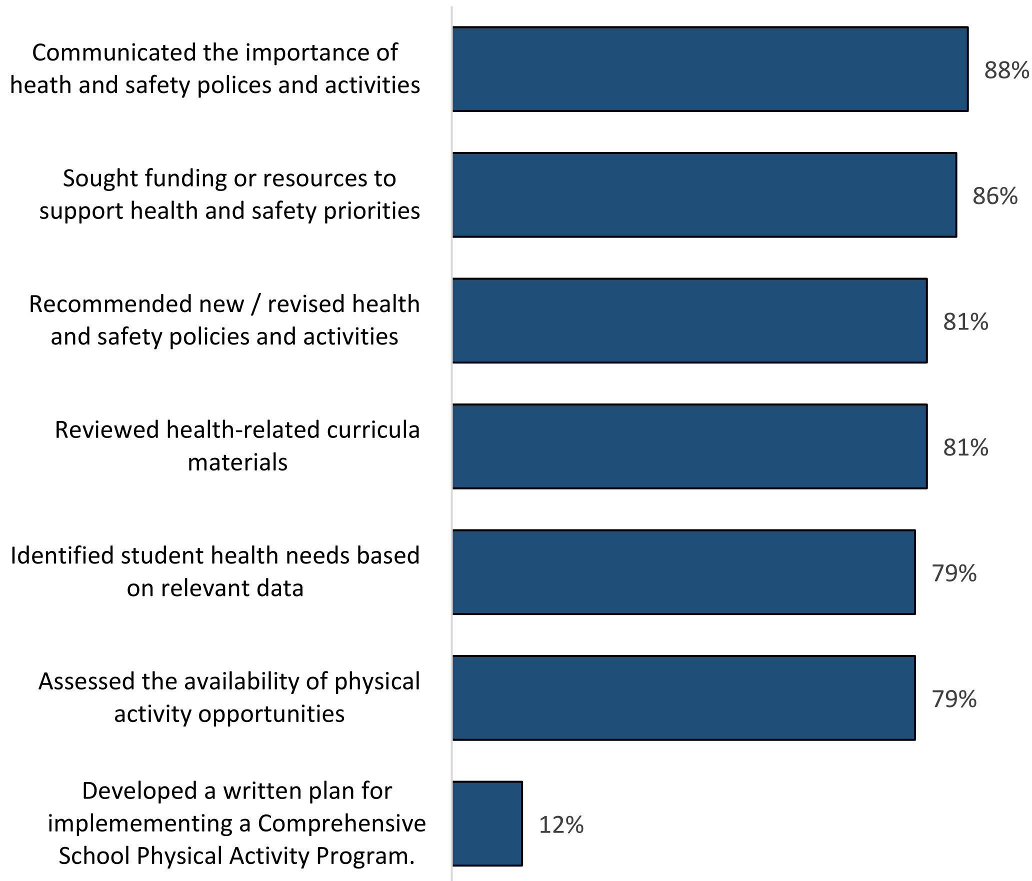
Because the response rates for both the principal and lead health educator surveys were at least 70%, the results are weighted and are representative of all public schools in Vermont with any grades 6 through 12. Note, however, schools that end with grade 6 are ineligible for the School Health Profiles. Their responses are not reflected in this report.

The following pages discuss what we know about school health teams, school health services, lead health educators in grades 6-12, and required health and physical education, followed by a more in-depth look at specific the health-related aspects of school policies and programs, prevention, and education. Where differences between school types are notable, results are presented for middle schools (below 9th grade) and high schools (9th grade and higher).

The CDC defines the type of school as:
[1] Middle schools with a high grade of 9 or lower;
[2] Junior/senior high schools with a low grade of 8 or lower and a high grade of 10 or higher; and
[3] High schools with a low grade of 9 or higher and a high grade of 10 or higher;

School Health Teams

Nine out of ten schools (91%) have at least one person who oversees or coordinates school health safety programs and activities, nearly eight in ten (78%) have at least one group such as a school health council or team that offers guidance on the development and coordination of policies and health-related activities. Specific activities performed by a school health team are shown below.



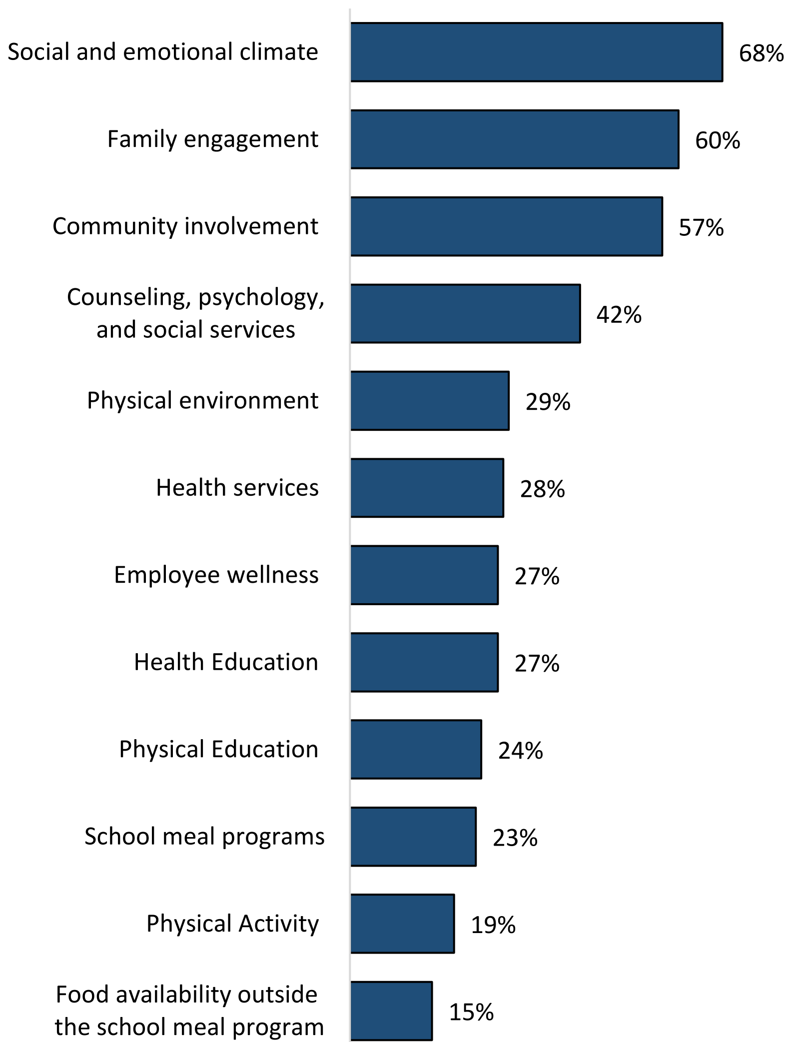
In addition to having a school health council or team, nearly eight in ten schools participate on a Supervisory Union or district wide health council (78%). Fifteen percent of schools indicated their SU/SD did not have a local health council.

[δ] Among schools that have a school health council or team

School Improvement Plans

Two thirds of all schools had a School Improvement Plan (SIP) that included at least one health-related objective. Of the 12 health-related objectives assessed, schools were most likely to include social and emotional climate (68%) and family and community involvement (60% and 57% respectively). Additional health topics included in a SIP are shown below.

Health-Related Objectives Included in School Improvement Plans



Nearly all high schools (96%) and about three quarters of middle schools (78%) reviewed health and safety data such as the Youth Risk Behavior Survey as part of the school improvement process.

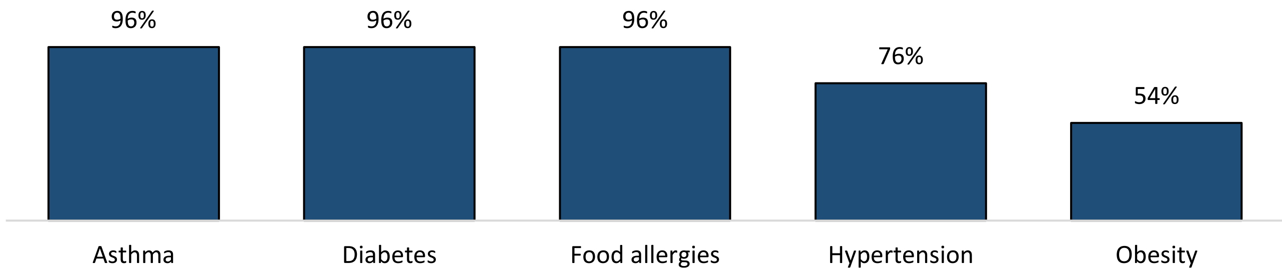
Additionally, schools indicated using the School Health Index or other self-assessment to assess policies, activities, and programs in nutrition (65%), tobacco-use prevention (61%), physical activity (61%), injury and violence prevention (46%), HIV/STD and pregnancy prevention (45%), and asthma (37%).

School Health Services

Three out of four schools (78%) have a full-time registered nurse on staff, one-third (33%) have a part time registered nurse to provide health services to students. About a quarter (27%) of schools have a school-based health center that offers health services to students on campus. High schools are more than two times as likely than middle schools to have these centers (44% vs 19%).

Most schools identify and track students with chronic conditions such as asthma, diabetes, and food allergies that may require daily or emergency management (96%). Fewer schools identify and track students with a current diagnosis of obesity (54%) or hypertension (76%). Overall, more than eight out of ten schools (82%) provide students with referrals to community-based health centers if they have been identified with chronic conditions or are at risk for activity, diet, and weight-related chronic conditions.

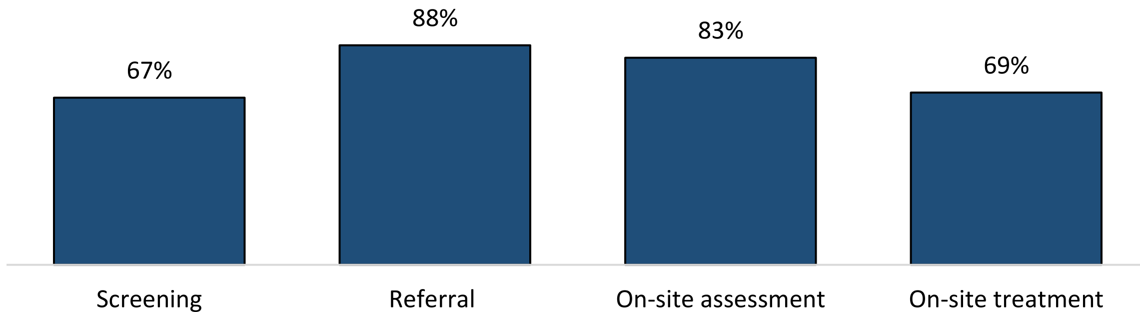
Chronic and Weight-Related Conditions Identified and Tracked in Schools



Three quarters (76%) of all schools have protocols to ensure eligible students with chronic conditions are enrolled in state or federally funded insurance programs.

Three-quarters (76%) of schools have a cooperative or formal agreement with an outside agency to provide mental health treatment. Internally, nine out of ten schools have either screening or referral procedures for students who have or are suspected to have mental health issues (94%) or have school staff or a provider within the school who can assess or provide treatment for students with mental health issues (87%). Specific services provided by schools are shown below.

Mental Health Services Provided On-site to Students



In addition to providing services or referrals for students with mental health, chronic conditions or diet and weight-related conditions, principals were also asked about sexual health services and services related to drug and alcohol issues. Detailed information about these services is provided in the following section on specific school policies, procedures, and prevention practices.

Lead Health Educators

In Vermont, about two-thirds (67%) of the lead health educators are certified, licensed, or endorsed by the state to teach health education. High school LHEs are significantly more likely than middle school LHEs to have this endorsement (89% vs 57%). The percent of lead health educators who are certified or licensed by the state has not changed significantly since the question was first asked in 2006.

A third of Vermont LHEs have 15 or more years of experience (34%), while one in five have two to five (22%) or six to nine (21%) years of experience. Fewer had only one year of experience (13%) or ten to 14 years of experience (11%). High school LHEs are significantly more likely to have 15 or more years of experience than middle school LHEs, and less likely to have only one year of experience.

Years of Experience in Teaching Health Education	Middle School - %	High School - %
1 year^[^]	17	4
2 to 5 years	21	19
6 to 9 years[^]	27	15
10 to 14 years	11	12
15 or more years[^]	23	50

Overall, six out of ten LHEs have professional preparation in education. Three in ten LHEs have a health and physical education combined degree, while 15% have a physical education degree and 14% have a health education degree. Few, 4%, have some other education degree. A third of LHEs have a background outside of education such as in biology or other science (13%), home economics or family / consumer science (11%), or counseling (5%).

Professional Preparation	Middle School - %	High School - %
Health and physical education, combined[^]	28	38
Health education[^]	9	35
Physical education[^]	15	8
Home economics or family and consumer science	8	8
Nursing[^]	19	4
Other education degree	3	4
Kinesiology, exercise science, or exercise physiology[^]	1	4
Counseling[^]	8	--
Biology or other science[^]	4	--
Public Health[^]	3	--
Other[^]	3	--

While six in ten LHEs in their first year of teaching do not have health education licensure, nearly two thirds (62%) of LHE with 2 to 5 years of experiences do. About nine out of ten LHE with ten or more years of experience are licensed (86% of those with 10-14 years of experience; 93% of those with 15+ years of experience). LHEs with a degree in health education or health and physical education combined (41%) are more likely to be licensed or endorsed by the state to teach health education compared to those with only physical education or kinesiology background (10%) or other degree (<10%).

[^] *Significant difference between middle and high schools*

Lead Health Educators

In addition to formal professional training, LHEs receive professional development such as attending conferences or workshops on teaching health and sexual education. In the previous two years, almost all schools (97%) provided professional development opportunities for those teaching physical education.

Generally, fewer LHEs report recently receiving professional development related to teaching students of various backgrounds and special needs compared to that related to pedological techniques specific to health education. Receipt of professional development on topics related to educating students of special populations and needs ranged from 12% (teaching students with limited English proficiency) to 48% (teaching students with physical, medical, or cognitive disabilities). In contrast, recent professional development activities related to teaching and assessment ranged from 40% (encouraging community and family involvement) to 56% (using interactive teaching methods). The following tables show the percent of LHE's who recently received professional development related to special populations, teaching and assessment in health education.

Professional Development Received Special Populations**	Middle School - %	High School - %	Overall - %
Teaching students with physical, medical, or cognitive disabilities	49	50	48
Teaching students of different sexual orientations or gender identities^	32	73	42
Teaching students of various cultural backgrounds^	28	42	30
Teaching students with limited English proficiency^	10	19	12

Professional Development Received Teaching and Assessment**	Middle School - %	High School - %	Overall - %
Using interactive teaching methods^	60	54	56
Classroom management techniques^	60	38	53
Assessing students in health education^	38	62	47
Teaching skills for behavior change	53	54	46
Encouraging community and family involvement^	49	31	40

When asked about what areas they would like to receive additional training related to special populations, LHEs cited teaching students of different sexual orientations or gender identities (69%) and teaching students with physical, medical, or cognitive disabilities (61%). The greatest disparity between professional development received and desired was for teaching students with limited English proficiency, where 12% of LHEs received training in this area during the previous two years, but four in ten said they wanted training opportunities in this area. Three-quarters of LHEs said they would like additional pedological training in the areas of encouraging community and family involvement (76%), teaching skills for behavior change (75%), and assessing students in health education (74%).

** *Options not mutually exclusive*

^ *Significant difference between middle and high schools*

Lead Health Educators

The SHP also asked LHEs to report on recent professional development specific to teaching sexual health, as well as state and local policies and services available. In the last two years, just over one in four received professional development related to policies or curriculum guidance regarding sexual health education (26%) or how to connect students to on-site or community based sexual health services (28%). High school LHEs are more than two times as likely to receive training on policies regarding sexual health education (46% vs 20%) and connecting students to sexual health services (54% vs 19%).

Likewise, high school LHEs were significantly more likely than middle school LHEs to receive professional development on teaching sexual health education. Professional development opportunities related to teaching sexual health are shown below. **

Professional Development Received Sexual Health Education #	Middle School - %	High School - %	Overall - %
Using a variety of effective instructional strategies to deliver sexual health education	28	65	37
Assessing student knowledge and skills in sexual health education	23	65	35
Building student skills in HIV, STD, and pregnancy prevention	28	61	36
Creating a comfortable and safe learning environment for students receiving sexual health education	31	57	41
Aligning lessons and materials with the district scope and sequence for sexual health education	31	54	41

When asked what professional development opportunities they would like to have related to sexual health education most LHEs said assessing student knowledge and skills in sexual health education (74%) and using a variety of effective instructional strategies to deliver sexual health education (73%). About two-thirds reported wanting training in aligning lessons and materials with the district scope and sequence for sexual health education (66%), building student skills in HIV, STD, and pregnancy prevention (65%), and understanding current district of school board policies/curriculum regarding sexual health education (65%).

** *Options not mutually exclusive*

All differences between middle and high school are significantly different

Lead Health Educators

In addition to pedagogical based professional development, in the past two years LHEs had opportunities to participate in topic focused training. The following table shows specific health topics covered during recent professional development opportunities.

Topics Covered in Professional Development**	Middle School - %	High School - %	Overall - %
Emotional and mental health^ ^	66	81	67
Violence prevention^	57	73	59
Alcohol / drug use prevention^	50	77	55
Physical activity and fitness	55	57	54
Human sexuality^	38	73	47
Suicide prevention	40	69	46
Injury prevention and safety^	47	42	42
HIV prevention^	30	58	39
Infectious disease prevention ^	38	42	35
Nutrition and dietary behavior^	33	42	34
STD prevention^	26	50	33
Tobacco use prevention^	38	27	33
Food allergies^	34	27	29
Pregnancy prevention^	20	50	29
Chronic disease prevention^	27	34	25
Epilepsy^	16	19	18
Asthma	16	15	15
Foodborne illness prevention^	16	19	15

The five most commonly report topics health education teachers reported wanting additional training in are: emotional and mental health (76%), human sexuality (72%), alcohol- or other drug-use prevention (69%), violence prevention (68%), and suicide prevention (68%).

** *Options not mutually exclusive*

^ *Significant difference between middle and high schools*

Required Education in Schools

Schools can provide materials to health and physical education teachers to help them teach. These materials may include a written curriculum, as well as goals and objectives, sequence of instruction, and methods for assessment.

Overall, six in ten schools provide teachers with a written general health education curriculum and a written curriculum for sexual health education.* Nearly eight in ten (78%) schools provide a written physical education curriculum.

Specifically, over three quarters (77%) of schools give health teachers goals, objectives, and expected outcomes, just over half provide health teachers with a chart describing the scope and sequence of health education and plans for how to assess student performance (54% and 55%, respectively). These materials are as likely to be provided to teachers for health and sexual health education, but significantly more likely to be provided to teachers for physical education courses.

Other materials provided for teaching physical education included resources for fitness testing (94%) and monitoring devices (83%). All high schools provided these, while nine out of ten middle schools provided resources for fitness testing, three quarters provided monitoring devices for those teaching middle school physical education. Data not shown below.

Two-thirds of all schools provide strategies that are age-appropriate, relevant, and actively engage students in learning (66%) or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth (62%).

Materials Provided to Those Who Teach Health, Sex, and Physical Education		Middle School - %	High School - %	Overall - %
A written curriculum	Health education^	55	65	60
	Sexual health education*^	55	67	61
	Physical education^	76	84	78
Goals, objectives, and expected outcomes	Health education^	73	85	77
	Sexual health education*^	66	83	72
	Physical education	96	96	96
A chart describing the annual scope and sequence of instruction	Health education	58	57	54
	Sexual health education*^	47	63	49
	Physical education^	67	88	74
Plans for how to assess student performance or methods to assess student knowledge and skills	Health education^	53	62	55
	Sexual health education*^	50	63	55
	Physical education^	84	88	87
Strategies in sexual health education are age-appropriate, relevant, and actively engage students in learning*		65	67	66
Curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth^		80	47	62

* *Among schools that teach sexual health education*
^ *Significant difference among middle and high schools*

Required Education in Schools

Health Education Standards focus on developing skills necessary to adopt, practice, and maintain health-enhancing behaviors as well as increasing knowledge on specific topics.[1]

Approximately nine in ten schools have health education curriculum that includes using decision making skills (91%), interpersonal communication skills to enhance health or reduce risks (90%), and goal setting (89%), practicing health-enhancing behaviors (90%), analyzing the influence of family, peers, culture, media and other factors on health behaviors (90%), and comprehending concepts related to health promotion and disease prevention in their health education curriculum (88%). Slightly fewer include teaching students how to assess health information, products, and services (85%) and how to advocate for personal, family, and community health (83%). Notably, all high school health education curriculum addressed these skills.

Health education curriculum covers a variety of topics ranging from alcohol and other drug use prevention to bullying and violence prevention. High schools are significantly more likely to teach each of the topics shown below, except infectious disease prevention.

Content Areas Covered in a Required Health Education Course	Middle School - %	High School - %	Overall - %
Physical activity and fitness^	93	100	95
Violence prevention^	89	100	92
Alcohol and other drug use^	84	100	91
Nutrition and dietary behavior^	87	100	91
Tobacco-use prevention^	86	96	90
Emotional and mental health^	84	100	89
HIV prevention^	79	100	87
STD prevention^	80	100	87
Human sexuality^	83	96	87
Injury prevention and safety^	81	89	81
Pregnancy prevention^	70	96	80
Chronic disease prevention^	61	96	73
Infectious disease prevention	73	73	73
Suicide prevention^	60	100	72
Foodborne illness prevention^	58	65	58
Food allergies^	57	69	56
Asthma^	24	46	29
Epilepsy or seizure disorder^	10	35	18

^ *Significant difference between middle and high schools*

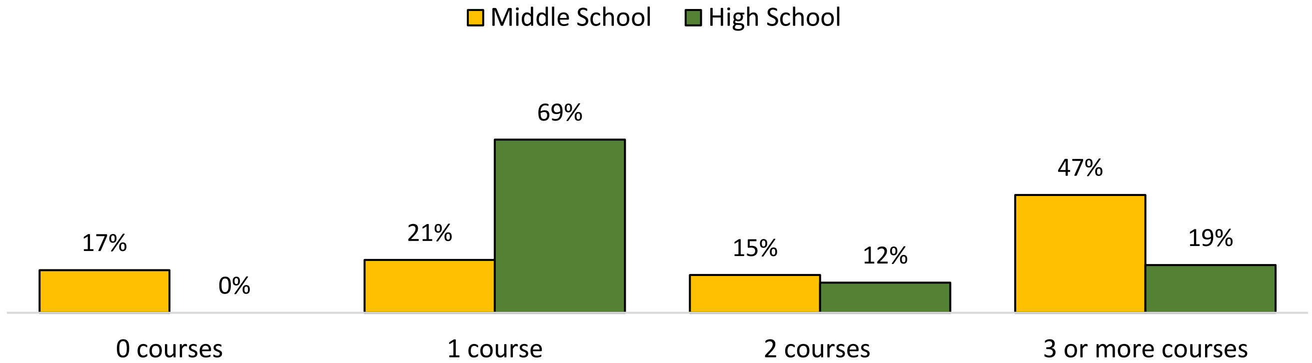
Required Education in Schools

Health education or instruction is not required to occur in a stand-alone health course taught to students. However, required *health education courses* are specific courses that students must take for graduation or promotion from school and include instruction about health topics such as injuries and violence, alcohol and other drug use, tobacco use, nutrition, HIV infection, and physical activity.

All Vermont high schools and most middle schools (83%) require at least some health education instruction, either in a required health education course or in another academic setting. Most schools (90%) require students to take at least one health education course, more than half (54%) require students to take two or more.

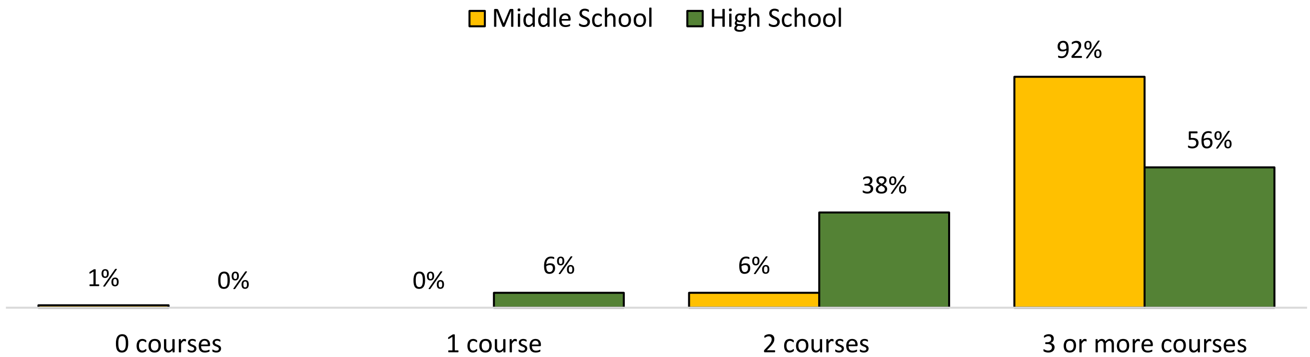
Middle schools are significantly more likely than high schools to require students to take multiple health education courses, however, they are less likely to require students who failed a course to repeat it (8% vs 96%). The number of required health education courses among middle and high schools are shown below.

Number of Required Health Education Courses By Type of School#



Nearly all schools (99%) require students to take at least one physical education course. About nine in ten schools (89%) require at least three physical education courses. As with health education, middle schools were significantly more likely to require students to take three or more courses.

Number of Required Physical Education Courses By Type of School#



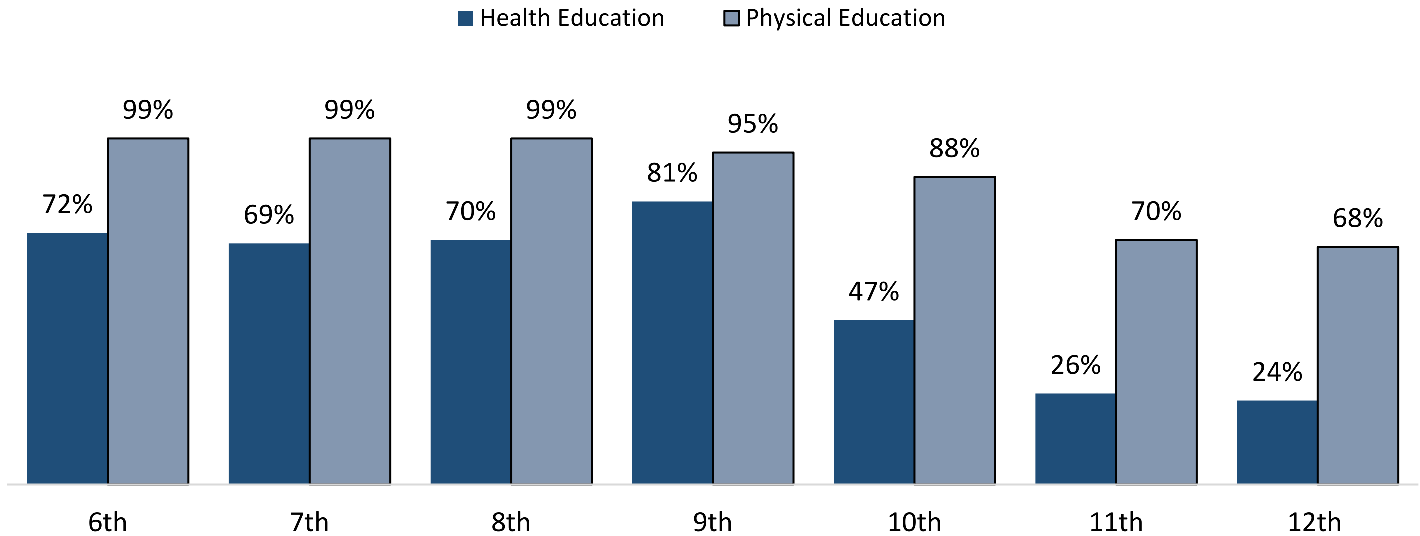
All differences between middle and high schools are significant

Required Education in Schools

Required health and physical education courses are distributed equally across grades 6 through 8. Nearly seven in ten schools require health education in grades six, seven and eight. Physical education courses are required in each grade 6 through 8 by almost all schools (99%).

Once students reach high school, required health and physical education courses decrease significantly after ninth grade. The majority of high schools require health education in ninth grade (81%). However, less than half require it in tenth grade (47%), about a quarter required it in 11th and 12th grades (26% and 24% respectively).

Similar requirements are also seen in physical education courses. Almost all schools require physical education courses to be taught in grades six through nine, however, only seven in ten require students to take a physical education course in 11th or 12th grade. Required health and physical education courses within a specific grade are shown below.



Policies, Programs, and Prevention

In addition to increasing knowledge and skills related to health education topics, an ecological approach to health education includes an alignment of health education across the school and community. It involves coordinating policies, processes, and practices within the school and community to improve the health and learning of young people.

The following section addresses what schools are doing in terms of teaching specific content, polices, processes, and practices related to tobacco use prevention, alcohol and other drug prevention, nutrition, sexual health, creating safe, inclusive environments and family and community involvement. These topics are presented in the context of what we know about youth behaviors in Vermont based on the results of the 2015 Vermont Youth Risk Behavior Survey (YRBS).

The YRBS can detect changes in risk behaviors over time and identify differences among ages, grades, and genders. With these data, we can focus prevention efforts and determine whether school policies and community programs are having the intended effect on student behaviors.

More information on the Vermont YRBS is available on the Vermont Department of Health website including general information about the YRBS, sample questionnaires, the Vermont YRBS reports, data briefs, local level results and reports from previous years.[2]

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

Among youth, alcohol is the most frequently abused substance, followed by marijuana and tobacco.[3] Substance use among youth has both immediate and long-term impacts. These impacts may depend on the substance, age of first use, frequency of use, and amount used.[4]

All youth are at risk for using tobacco, alcohol, and other drugs and alcohol. Substance use among youth depends individual factors and is influenced by peers, family, community, school, and other societal factors. The likelihood one will use and the impact of that use depends on the number and type of risk factors and protective factors.[5, 6] However, no single factor determines whether someone will develop a substance use problem.[4, 7] Many risk factors can be modified through prevention programs, connections with caring adults, school engagement, and developing good coping skills.

Changing the Balance to Reduce Substance Use Among Youth:
Making protective factors outweigh risk factors

Protective Factors

- Resiliency
- Self-confidence not to use and to resist peer pressure
- Feeling accepted and supported in one's school and community
- Family, school, and community norms that provide clear and consistent messages about not misusing substances
- Recognition for positive behavior and motivation to engage in positive behaviors
- Positive adult role models
- Involvement in school, spiritual, or community activities
- Academic competence
- Early intervention

Risk Factors

- Use at an early age or frequent use and high risk use (i.e. binge drinking)
- Peer pressure and peer substance use
- Low perceptions of harm and easy access
- Perceived social norms including media portrayal of use and perceptions that substance use is acceptable by family and peers
- Genetic factors and family history of substance use
- Family problems, conflict, unclear expectations
- Low connection to school or community (i.e. not feeling accepted, valued, welcome)
- Poor coping skills and impulse control

Preventing substance use requires a comprehensive approach and coordinated efforts. Prevention through effective policies, education, early intervention, and family and community engagement can impact to degree to which risk factors impact behaviors, reduce risk-taking and problem behaviors associated with alcohol, tobacco, and other drug use while promoting factors that support health lifestyles, communities and fosters resiliency.[3, 5, 6]

It has been shown that evidence-based school prevention programs can save Vermont $18 for every $1 invested.[4] The Vermont Department of Health and Agency of Education have invested in school- and community-based prevention grants and programs. For example, Vermont schools also may obtain federal and state grants for substance abuse and mental health services such as the Partnerships for Success grant, Regional Prevention Partnership grant, School-based Substance Abuse Services grant, and Comprehensive School-Based Tobacco Use Prevention grant. In addition, VDH provides funding for Student Assistance Professionals (SAP) work with schools to provide screening, crisis services, education and other programs related to alcohol, tobacco, marijuana and other drugs, and mental health and state alcohol and drug abuse regional prevention consultants (PCs).

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

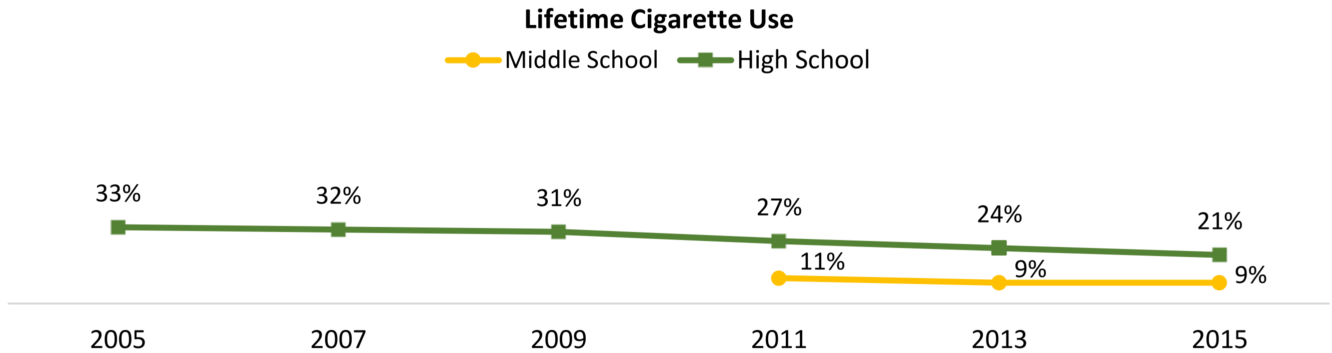
What we know: Tobacco Use

2015 Vermont Youth Risk Behavior Survey

Cigarettes

Over the past decade, there has been a significant decline in the percent of youth who have smoked a cigarette during their lifetime and who have smoked at least one time during the past 30 days.

In 2015, nearly one in ten middle school students and two in ten high school students ever smoked a cigarette. During the past 30 days, two percent of middle schools smoked at least once, one in ten (11%) high school students did so. Among high school students, lifetime and current cigarette use has been declining since 2005 (33% at 18%, respectively). Smoking prevalence continued to significantly decrease from 2013 to 2015.



Among middle school students who currently smoke cigarettes, about half (45%) smoked on one or two days and less. On days smoked, about two thirds (64%) smoked one cigarette or less. Frequency of use varied greatly among high school students. Nearly three in ten high school students smoked on one or two days in the last month, however, an equal amount also smoked every day (29% and 28%, respectively).

Electronic Vapor Products and Flavored Tobacco Products

In 2015, lifetime and current use of electronic vapor products was added to the middle and high school Youth Risk Behavior Survey. Ever using flavored tobacco products was also added to the high school survey. Electronic vapor products were described to include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens. Flavored tobacco products include any tobacco product flavored to taste like mint, clove, spice, candy, fruit, chocolate, or other sweets.

In their lifetime, less than one in ten middle school (7%) have used electronic vapor products, while three percent used electronic vapor products in the last month. Among high school students, three in ten reported ever using electronic vapor products, 15% used them in the last month. A quarter (24%) of high school students have tried flavored tobacco products.

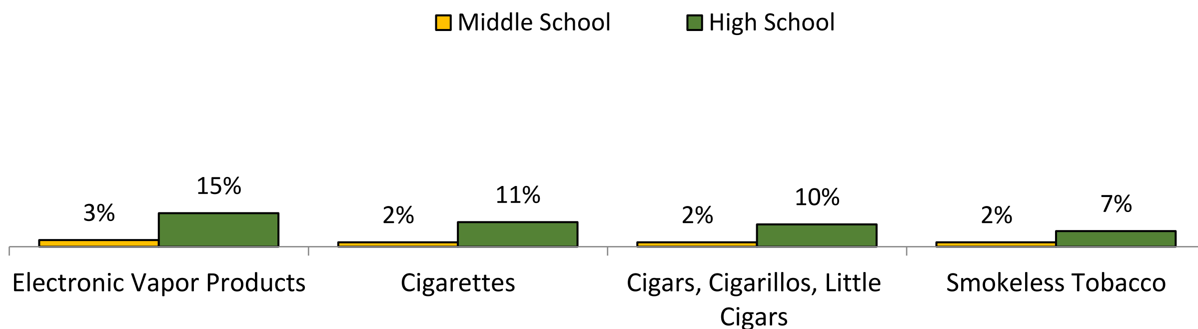
What we know: Tobacco Use

2015 Vermont Youth Risk Behavior Survey

Other Tobacco Products

In the past 30 days, two percent of middle school students smoked cigars, cigarillos, or little cigars or used smokeless tobacco. One in ten high school students smoked cigars, cigarillos, or little cigars and seven percent used smokeless tobacco in the past 30 days.

Current Tobacco Use by Product Type, Past 30 Days

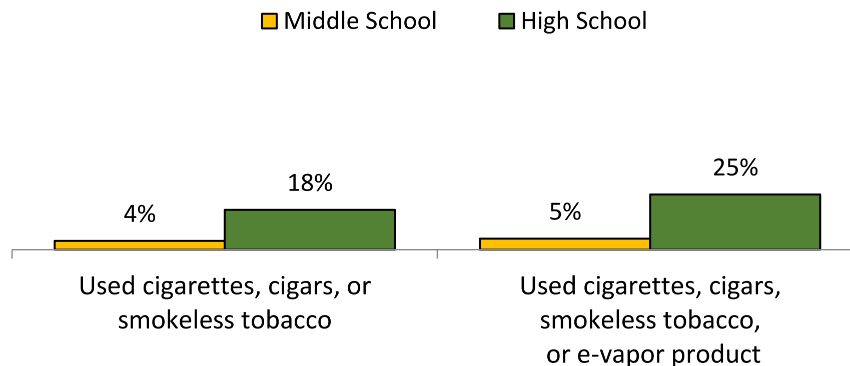


Overall, more students reported using electronic vapor product during their lifetime and during the past 30 days compared to all other tobacco products.

Any Tobacco Product Use[δ]

Nearly two in ten (18%) of high school students and four percent of middle school students used cigarettes, cigars, or smokeless tobacco on at least one day during the previous 30 days. This increases to a quarter of high school and five percent of middle school students when including electronic vapor products. Six percent of high school students used electronic vapor products exclusively in the last month.

Tobacco Product Use, Past 30 Days



[δ] In 2015, the Vermont YRBS only asked about lifetime use of flavored tobacco products. This question was not asked nationally. Therefore, the use of any tobacco product with or without electronic vapor products does not include the percent of students who have ever used flavored tobacco products

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

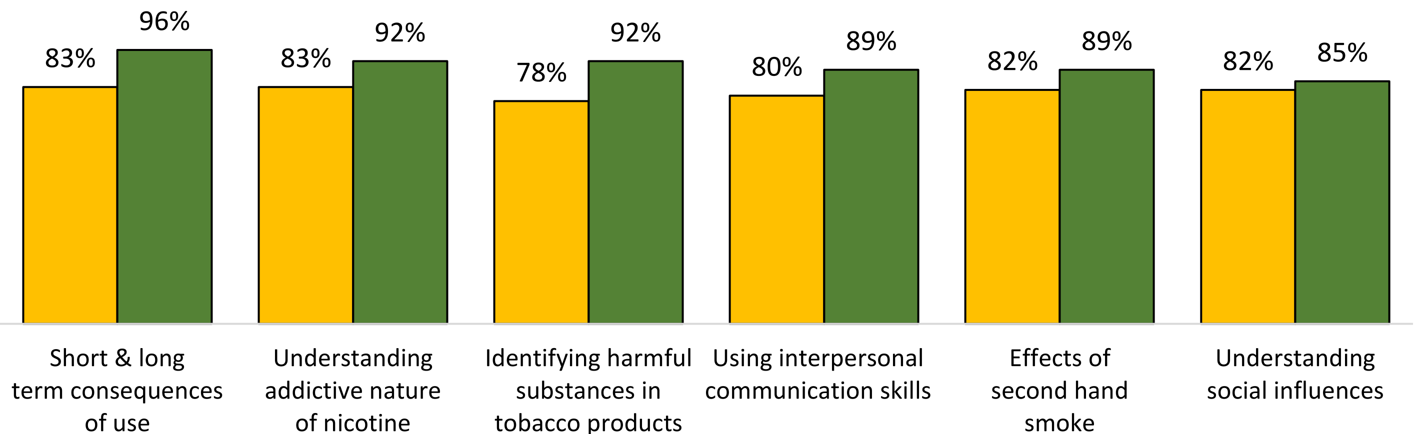
What we are doing: Tobacco Prevention Education

2016 Vermont School Health Profiles

As with the percent of students smoking cigarettes, the proportion of schools teaching about tobacco-use prevention topics has also decreased over the last decade (94% in 2008 vs 90% in 2016).

Nineteen key tobacco prevention topics were identified on the 2016 SHP. A third (37%) of schools taught all 19 tobacco prevention topics in a required health education course. High schools (48%) are significantly more likely to teach all 19 topics compared to middle schools (33%) and are more likely than middle schools to teach each individual topic.#

Six Most Commonly Reported Tobacco Use Prevention Topics Taught in a Required Health Education Course#



Other tobacco use prevention topics taught in required health education courses include: identifying why students use tobacco (81%), identifying social, economic, and cosmetic consequences of tobacco use (79%), the relationship between using tobacco, alcohol, and other drugs (77%), the effects of tobacco use on athletic performance (74%), use of goal setting and decision making skills to avoid tobacco use (73%), understanding school policies and community laws (73%), the effects of nicotine on the adolescent brain (73%), the benefits of tobacco cessation (72%), treating of tobacco addiction (70%), supporting others who want to quit or abstain from tobacco use (67%), identifying harmful effects of tobacco use on fetal development (66%), finding valid information and services (66%), and making accurate assessments of peer use (65%).#

All differences between middle and high schools are significant

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

What we are doing: Tobacco Prevention Policies and Services

2016 Vermont School Health Profiles

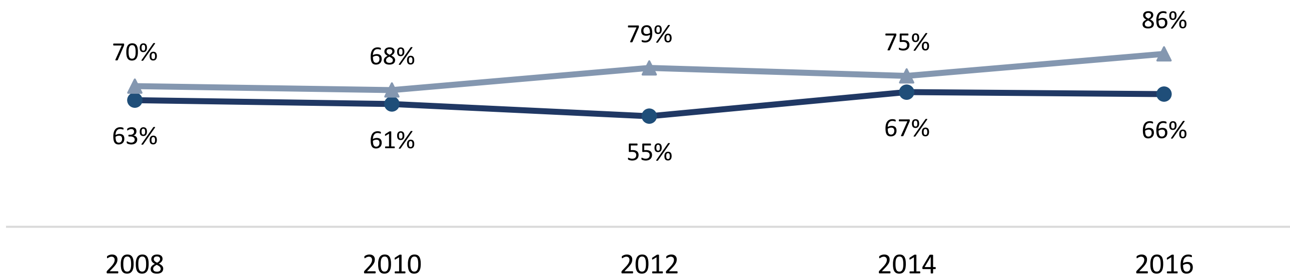
Tobacco Use Policies

All schools in Vermont have policies prohibiting tobacco use during school hours for students, faculty, and staff. However, what is included in this policy varies among schools.

Two-thirds of all schools have policies that mandate a “tobacco-free environment” in which tobacco use is prohibited by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds and at off-site school events at all times. Most schools designate areas where tobacco use is prohibited by posting “tobacco-free school zone” signs (86%). High schools are significantly less likely than middle schools to post tobacco-free school zone signs (79% vs 92%), however, they are more likely to have a tobacco-free environment (75% vs 61%).

Since 2008, the percent of schools with tobacco-free environments and who use signage to designate these areas have significantly increased.

Tobacco-Free Policies, among all schools



What we are doing: Tobacco Prevention Policies and Services

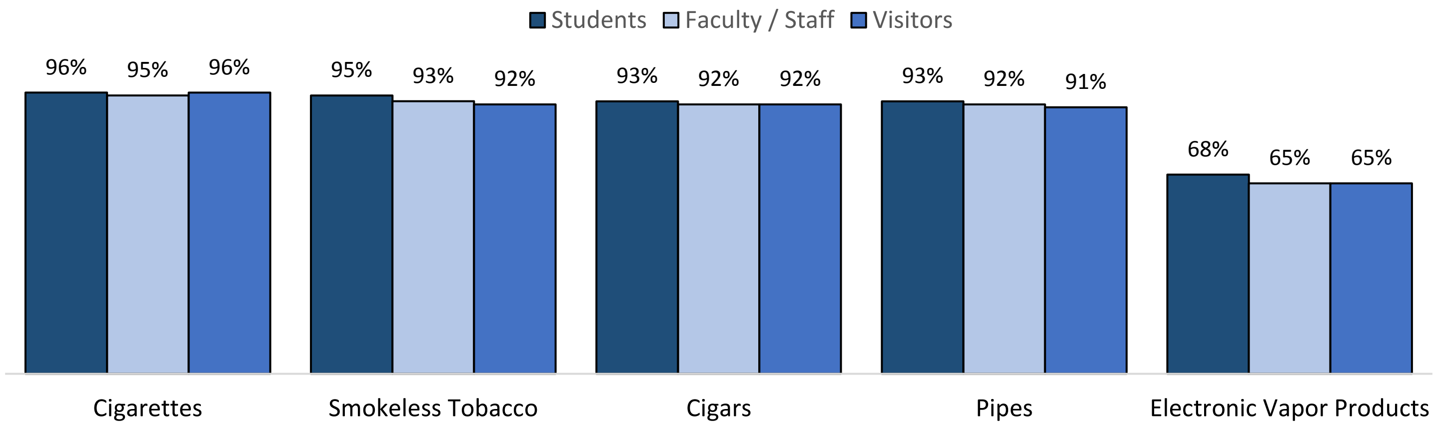
2016 Vermont School Health Profiles

Tobacco Use Policies

All schools have tobacco policies that prohibit use during school hours including in school buildings and on school grounds, parking lots, and playing fields for students and faculty/staff. Slightly fewer schools (98%) have policies regarding tobacco use by visitors during school hours. Schools are less likely to have tobacco policies during non-school hours. One in ten schools have no policy regarding tobacco use during non-school hours for students (7%), faculty/staff (10%), and visitors (10%).

More than 90% of school policies explicitly prohibit the use of cigarettes, smokeless tobacco, cigars, and pipes by all students, faculty/staff and visitors. Fewer, only two-thirds, schools specifically ban the use of electronic vapor products. At all schools, policies prohibiting the use of tobacco products by students are more common than those regarding use by faculty/staff. In addition, schools are more likely to prohibit the use of cigarettes among students, faculty/staff, and visitors compared to all other tobacco products.

Types of Tobacco Products Prohibited During School-Related Activities



High schools are significantly more likely than middle schools to have tobacco polices prohibiting the use of each tobacco product. Ninety-six percent or more of high schools prohibit use of each tobacco product by all users. All high schools prohibit use of cigarettes by students, faculty/staff, and visitors. Likewise, students are banned from using smokeless tobacco at all high schools. Comparatively, about nine in ten middle schools, prohibit the use of tobacco products by students, faculty/staff, and visitors.

What we are doing: Tobacco Prevention Policies and Services

2016 Vermont School Health Profiles

Tobacco Cessation Services:

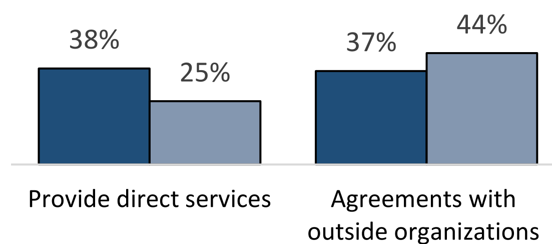
In addition to prohibiting tobacco use, a third of schools (35%) provide tobacco cessation services to students, faculty, and staff either through direct services at school or arrangements with providers not on school property. The percentage of schools providing either direct or indirect tobacco cessation services has not significantly changed since 2008 (32% each).

Schools are more likely to provide direct cessation services for students (38%) than for faculty and staff (25%). However, provision of direct tobacco cessation services for faculty and staff has significantly increased from 14% in 2008.

About four out of ten schools have arrangements with other organizations or health care providers to provide tobacco cessation services (37% for students; 44% for faculty/staff).

Overall, high schools (62%) are significantly more likely to provide direct or indirect services for students, faculty, and staff than middle schools (19%).

Tobacco Cessation Services Provided to Students, Faculty, and Staff



Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

What we know: Alcohol and Marijuana Use

2015 Vermont Youth Risk Behavior Survey

Lifetime and Current Alcohol Use:

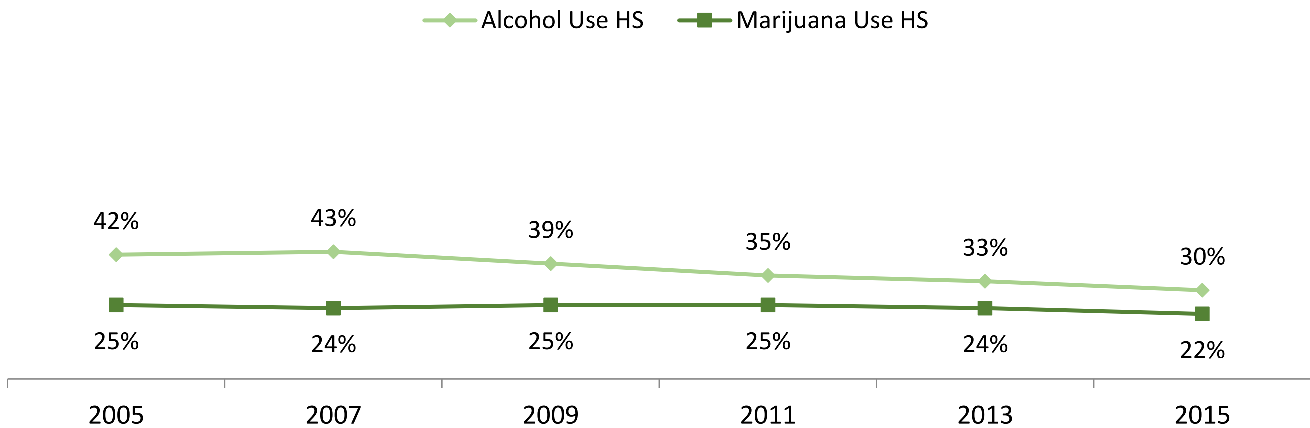
Overall, nearly one in five (17%) middle school students reported ever drinking alcohol and six percent drank during the past 30 days. More than half (56%) of high school students have ever drank more than a sip or two of alcohol while three in ten have had alcohol during the past 30 days. Lifetime and current alcohol use among middle school students is statistically unchanged from 2013 to 2015, while among high school students use has significantly decreased since 2005 and since 2013.

Among high school students who drank alcohol during the past 30 days, about half (51%) drank once or twice, while (12%) drank on ten or more days. When drinking alcohol during the past 30 days, a third (36%) reported having one or two drinks and nearly half (45%) drank at least five drinks.

Lifetime and Current Marijuana Use:

Among middle school students, nearly one in ten (7%) have ever used marijuana and four percent used it in the past 30 days. Nearly four in ten (37%) high school students have ever used marijuana, while more than one in five (22%) used marijuana in the last month. Six percent of high school students used it before age 13. Lifetime and current marijuana use among middle school students is unchanged since 2011. Among high school students, marijuana use has significantly decreased since 2005 and since 2013.

Among high school students who used marijuana during the past 30 days, almost half used it ten or more times (45%). Less than a third (31%) used it one or two times during the past 30 days.



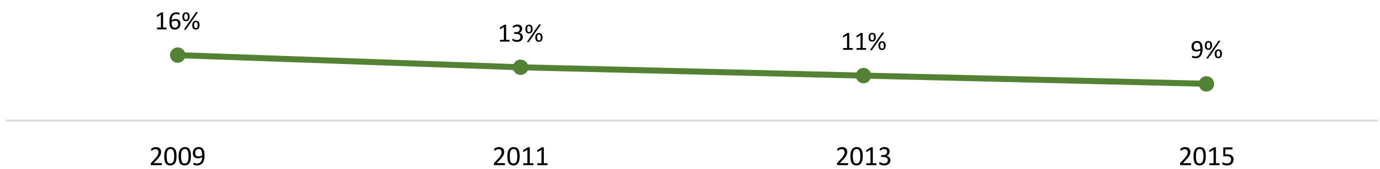
What we know: Other Drug Use

2015 Vermont Youth Risk Behavior Survey

Prescription Drug Use:
Few middle school students (3%) have ever misused prescription drugs such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax. Nearly four times as many (11%) high school students have misused either a prescription stimulant or prescription pain reliever in their lifetime.

Specifically, among high school students, 9% have misused a prescription pain medicine, 7% have misused a prescription stimulant such as Adderall during their lifetime. The percent of high school students ever misusing a prescription drug significantly decreased from 2013 to 2015 (13% and 11% in 2013, respectively).

Percent of High School Students Who Have (Mis)Used a Prescription Pain Reliever, Lifetime



The percent of high school students who misused a prescription medicine during the past 30 days also decreased from seven percent in 2013 to five percent in 2015. Three percent of students reported misusing a prescription stimulant and four percent reported misusing a prescription pain reliever.

Other Illicit Drug Use:
During their lifetime, one in twenty high school students have ever used cocaine. Three percent reported using methamphetamines, and two percent used heroin. Seven percent of high school students and five percent of middle school students reported ever using inhalants. Use of methamphetamines, heroin, and inhalants are unchanged since 2013.

Nearly one in five high school students (18%) were offered, sold, given an illegal drug on school property during the past 12 months. Access to illegal drugs on school property has significantly decreased since 2005 (23%) but remains the same as in 2013.

What we know: Perceptions of Alcohol and Marijuana Use

2015 Vermont Youth Risk Behavior Survey

Perceptions around use and harm of alcohol and marijuana decrease significantly as students' progress through school. A third of middle school students think it would be sort of or very easy to get alcohol (36%), while one in seven (14%) believe marijuana would be easy to access. In contrast, about two-thirds of high school students believe it would be sort of easy or very easy to get alcohol (69%) and marijuana (62%).

While nine in ten middle school students believe that it was wrong for someone their age to use marijuana (90%) and drink alcohol (88%), only about half of high school students believe the same (53% alcohol, 56% marijuana). Likewise, at least half of middle school students think people are at great risk of harm from binge drinking once or twice a weekend (48%) and using marijuana regularly (59%), while around three in ten high school students reported the same (38% alcohol, 27% marijuana).

Perceptions of harm and parental disapproval of marijuana use have decreased over time. Significantly fewer high school and middle school students believe their parent would think it was wrong or very wrong to use marijuana and that marijuana was harmful if used regularly in 2015 compared to 2013. Similar changes in one's perception are also seen for alcohol use, with fewer middle school students believing that binge drinking would be harmful to someone their age in 2015 than in 2013. Among high school students, fewer think their parents would disapprove of someone their age drinking alcohol in 2015 compared to 2013.

Perceptions of Alcohol Use, High School Students	2013	2015	Compared to 2013	Perceptions of Marijuana Use, High School Students	2013	2015	Compared to 2013
Believe their parents would think it is wrong or very wrong for them to use marijuana	74%	72%	⬇	Believe their parents would think it is wrong or very wrong for them to drink alcohol	82%	80%	⬇
Think people their age are at great risk of harm if they binge drink once or twice a weekend	38%	38%	No Change	Think people their age are at great risk of harm if they use marijuana regularly	31%	27%	⬇
Believe it is wrong or very wrong for students their age to smoke marijuana	49%	53%	⬆	Believe it is wrong or very wrong for students their age to drink alcohol	57%	56%	No Change

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance Use Prevention

What we are doing: Alcohol and Drug Prevention Education

2016 Vermont School Health Profiles

Overall, nine in ten (91%) schools address alcohol and other drug-use prevention in a required health course, a significant decrease from 93% in 2008. Of the six alcohol and drug-use prevention topics included in the School Health Profiles, nearly eight out of ten schools (79%) teach all six, while few (4%) do not cover any topics. Below is a breakdown of the percent of middle and high schools who teach drug and alcohol related content in a required course. All differences are significant.

	Middle School - %	High School - %	Overall - %
Taught signs and symptoms of alcohol and other drug use, including the progression from non-use through addiction	75	100	84
Taught short and long term effects of alcohol, tobacco, and other drugs on health.	92	100	94
Taught how messages from the media, friends, family and culture influence young people to use alcohol, tobacco, and other drugs	92	100	95
Taught finding valid information and services related to health issues related to alcohol, tobacco, and other drugs	82	100	88
Taught health benefits of abstaining from use of alcohol, tobacco, and other drugs	91	96	94
Taught use of effective interpersonal communication skills to counter influences and resist pressures to use alcohol and other drugs	90	96	93

What we are doing: Alcohol and Drug Prevention Policies and Services

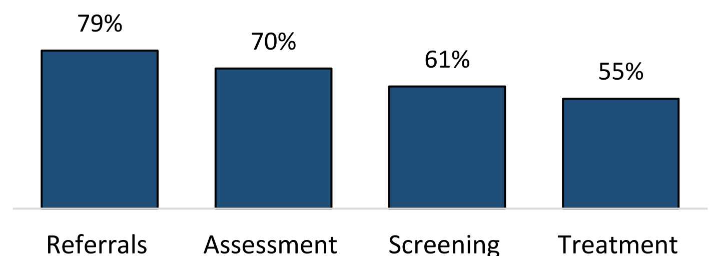
2016 Vermont School Health Profiles

Almost all schools (99%) have a drug and alcohol policy. These policies include providing education (95%), referrals to treatment (89%), counseling (91%), and discipline (96%).

Nearly eight in ten schools have staff or a provider on school property who can provide an assessment, screening, treatment, or referral for students who are referred for or suspected to have drug or alcohol problems. This was most frequently in the form of referrals. A third (38%) of all schools have someone available who can provide all four services.

Two-thirds (64%) of schools have a cooperative or formal agreement with an outside agency to provide assessment and treatment services off-school property to students known or suspected to have substance use issues.

Schools with Alcohol and Drug Related Procedures and On-site Staff Who Deliver Alcohol and Drug Related Services



Policies, Programs, and Prevention
Physical Education and Physical Activity

Physical activity has numerous benefits for children and adults. Regular physical activity during childhood and adolescence increases the chance one will have a healthier adulthood.[5] It decreases risk factors for chronic diseases, reduces symptoms of anxiety and depression, helps maintain favorable body composition, and increases bone-density which peaks during puberty.[7] School-based physical activity is shown to have strong associations with cognitive development and academic performance. Physical activity in schools includes immediate and long term benefits. It increases the rate at which students learn and increases attention and memory while decreasing disruptive behavior.[8]

Physical Activity Guidelines for Americans recommend that youth have 60 minutes or more of physical activity each day.[9, 10] Most should be performed at either moderate or vigorous intensity level, such as riding a bike, playing sports, dancing, or active games like tag. Other activities should include muscle- and bone-strengthening activities such as gymnastics, playing on a jungle gym, locomotor activities for younger students and weight-lifting for older students.

Physical activity can be accumulated throughout the day in a variety of settings. Schools provide an ideal setting for students to be active and learn the skills necessary to enjoy physical activity and to participate in lifetime physical activity.[11]

In schools, physical activity goes beyond required physical education courses. It can be formal or informal, integrated into before and after-school programs such as physical activity clubs, intramural and interscholastic sports, as well as breaks during school including recess and breaks built into classroom lessons. Regardless of skill level, all students should have opportunities to participate.

> ***"Each school shall offer options for students in grades K-12 to participate in at least 30 minutes of physical activity within or outside of the school day. Physical activity may include recess and movement built into the curriculum, but does not replace physical education classes."***
>
> **Vermont Agency of Education**
> Education Quality Standards, August 2014

In order for schools to expand opportunities for physical activity and knowledge for sustaining physical activity, the CDC and SHAPE America collaborated to help schools develop a comprehensive plan for physical activity.[12] A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach for schools to provide opportunities for students to meet the nationally-recommended 60 minutes of daily physical activity and to become physically educated and well-equipped for a lifetime of physical activity. It builds upon providing quality physical education to offering physical activity before, during, and after school, staff involvement, and family and community engagement.

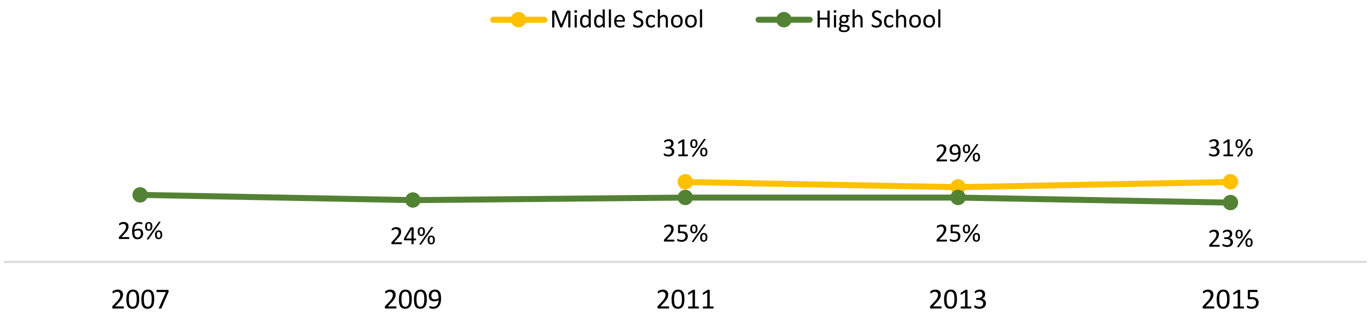
What we know: Physical Activity

2015 Vermont Youth Risk Behavior Survey

Three out of ten middle school students (31%) and a quarter of high school students (23%) currently meet physical activity guidelines for youth.

While the proportion of middle school students meeting physical activity guidelines significantly increased since 2013 (31% vs 29%), not participating in 60 minutes of physical activity on any day during the past week also increased (6% in 2013, 8% in 2015). Among high school students, meeting physical activity guidelines significantly decreased from 25% in 2013 to 23% in 2015. In addition, one in seven high school students (14%) reported not getting 60 minutes of physical activity on any day during the past week, a significant increase from 2013 (13%).

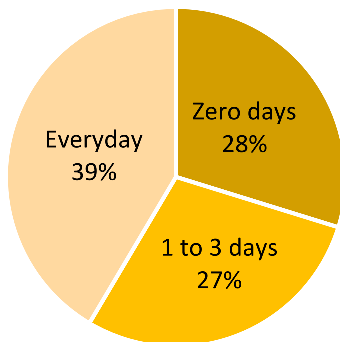
Participation in at Least 60 Minutes of Physical Activity Per Day, Last Week



What we know: Physical Activity Breaks in Middle Schools[εε]

2015 Vermont Youth Risk Behavior Survey

Frequency of Physical Activity Breaks in School, Among Middle School Students



Physical activity during the school day includes integrating physical activity into classroom lessons, providing short physical activity breaks in the classroom, and providing lunch time clubs or intramural programs.[10]

Daily physical activity breaks during class are reported by four in ten middle school students. Sixth graders (48%) are significantly more likely than older students (36% in 7th and 35% in 8th grade) to receive physical activity breaks during the school day.

εε *Questions about physical activity breaks at school were only asked on the middle school YRBS*

What we are doing: Physical Activity Related Topics Taught

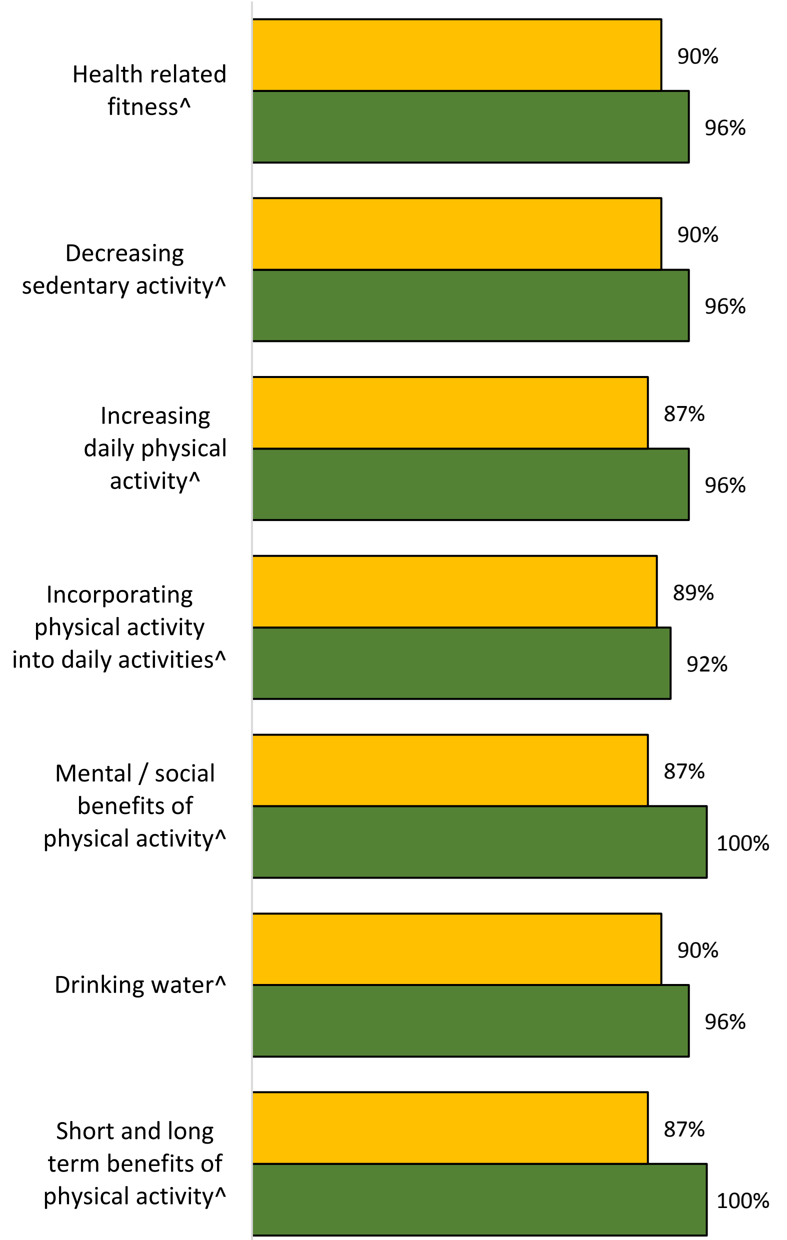
2016 Vermont School Health Profiles

Nearly all (95%) schools teach physical activity and fitness in a required health course. Most cover a range of physical activity topics in a required course, with six in ten (58%) including all 13 physical activity topics.

Other than assessing BMI (49%), all topics are taught by at least seven in ten schools. Topics covered by more than nine in ten schools are shown to the right. Other topics include the proper use of safety equipment (84%), the dangers of performance enhancing drugs (75%), accepting body size differences (74%), and weather-related safety (74%).

High schools are more likely to cover physical activity and fitness topics compared to middle schools for all topics excluding phases of a workout and recommended physical activity.

Inclusion of most physical activity topics in a health course has remained consistent over the past decade. Exceptions include a significant decrease in schools teaching weather-related safety (79% to 74%) and accepting different body sizes (84% to 74%). The percentage of schools currently teaching students about decreasing sedentary activities significantly increased compared those in 2008 (86% to 93%). Since first asked in 2014, fewer schools are currently teaching about the relationship between diet and chronic diseases (76% to 66%), assessing BMI (58% to 49%), and using safety equipment (87% to 84%).



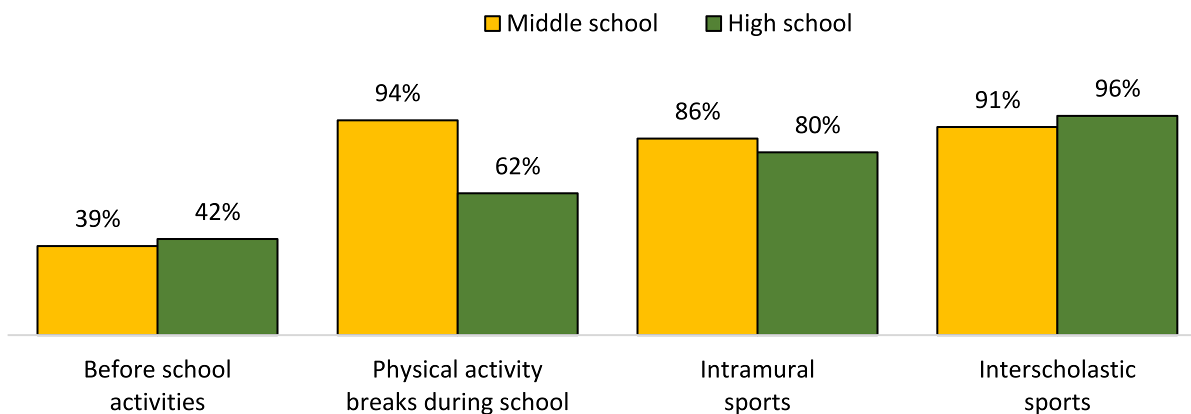
^ *Differences between Middle and High Schools significantly different*

What we are doing: Physical Activity in Schools

2016 Vermont School Health Profiles

Overall, schools are most likely to offer opportunities for physical activity after school, either through interscholastic sports (94%) or intramural sports and physical activity clubs (84%), followed by opportunities during the day (84%) and physical activity breaks during school (82%). Notably, most middle schools offer physical activity breaks during school (94%), however, less than two-thirds (62%) of high schools do so. Less than half of all schools offer physical activity before school (42%).

Opportunities For Physical Activity Outside of Physical Education Courses[#]



Opportunities for physical activity before the school day decreased from 48% in 2014, when first asked, to 42% in 2016. Physical activity opportunities during the day and after school have increased since first asked. Since 2012, physical activity breaks in the classroom have increased from 69%, while opportunities interscholastic sport programs increased from 86%. Opportunities for intramural sport programs or physical activity clubs increase from 79% in 2008 to 84% in 2016.

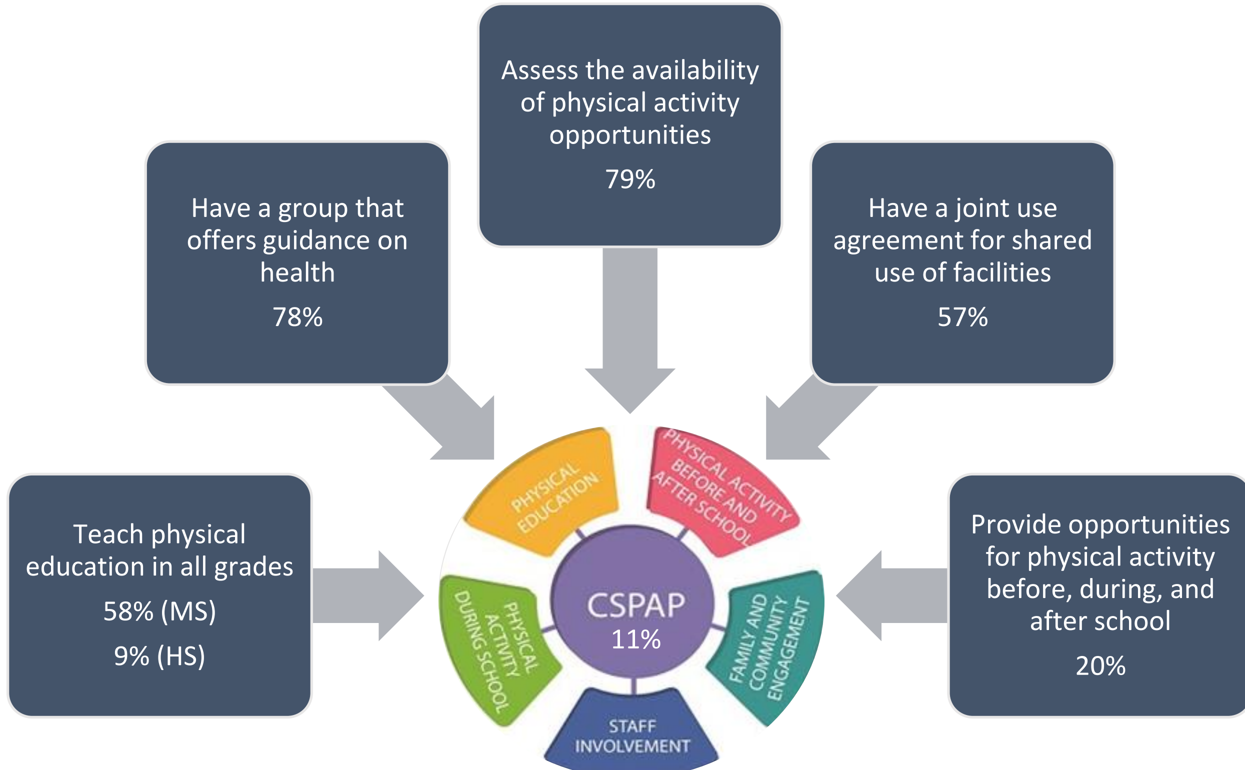
[#] *All differences between middle and high schools are significant*

What we are doing: Comprehensive School Physical Activity

2016 Vermont School Health Profiles

Comprehensive school physical activity programs (CSPAP) encourage schools to teach physical education courses in all grades, have a group that offers guidance on the development of policies or coordinates activities on health-related topics and assess the availability of physical activity opportunities, and have a joint use agreement for shared use of school or community physical activity or sports facilities.[8] In addition, schools should also provide physical activity breaks in the classroom during the day, intramural sport or physical activity programs after school, and opportunities for students to participate in physical activity before the school day.

One in ten (12%) of schools reported having a school health council or team working to develop a written plan for implementing a CSPAP plan, in the last year. Just over one in ten schools (11%) have a comprehensive school physical activity program in their schools. High schools (4%) are significantly less likely to have a CSPAP than middle schools (14%). The percent of schools with CSPAP significantly increased from 7% in 2014 to 11% in 2016.



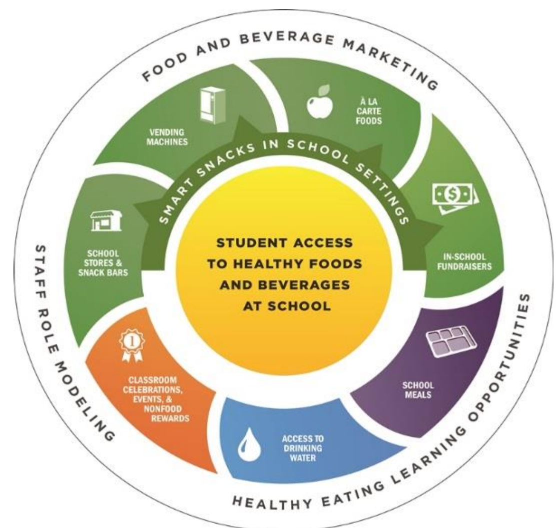
Policies, Programs, and Prevention

Nutrition Environment and Services

The 2015–2020 Dietary Guidelines for Americans recommend that children and adolescents follow a healthy eating pattern that includes a variety of fruits and vegetables, whole grains, fat-free and low-fat dairy products, and a variety of protein sources.[13] In addition, youth should increase water consumption, reduce sodium intake and limit calories from solid fats and added sugars. However, most youth do not follow the current dietary guidelines with 40% of their diet coming from empty calories such as those found in soda, sugar-sweetened beverages, dairy and other processed dessert, pizza, and whole milk.[14]

Most U.S. children attend school for 6 hours a day and consume as much as half of their daily calories at school .[15, 16] The CDC recommends that schools implement policies and practices to create a nutrition environment that supports students in making healthy choices. A healthy school nutrition environment helps students develop lifelong healthy eating behavior by providing students with nutritious and appealing foods and beverages, consistent and accurate messages about good nutrition, and ways to learn about and practice healthy eating.

The school nutrition environment includes multiple components within the school grounds. These include food and beverages available during school meals, "Smart Snacks", access to water, and other areas where students may access food and beverages such as in the classroom and at school events.[16] In addition the school nutrition environment addresses opportunities to learn about healthy eating information, positive role modeling, and the messages students encounter about food, beverages, and nutrition throughout all schools.



The Vermont Agency of Education administers federal programs that support nutritious high-quality meals and snacks in schools.[17] Federal programs include: National School Lunch Program, School Breakfast Program, After School Snack Program, Community Eligibility Provision, Seamless Summer Option and Summer Food Service Programs, and the Fresh Fruit and Vegetable Program.

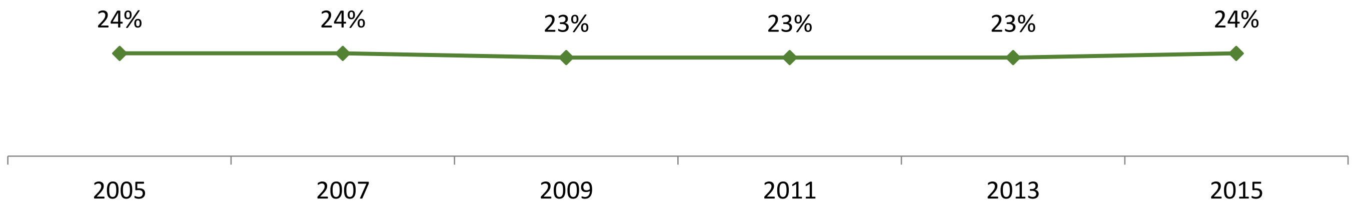
In addition, many Vermont schools work with local farmers and community organizations to provide education and access to whole, fresh, and local foods.

What we know: Fruit, Vegetable, and Beverage Consumption Among High School Students
2015 Vermont Youth Risk Behavior Survey

Fruit and Vegetable Consumption[ε]

In 2015, one in four high school students (24%) ate fruits and vegetables five or more times per day in the past seven days. Students are significantly more likely to consume two or more fruits per day (34%) than three or more vegetables (18%). Over the past ten years, consumption of five or more fruits or vegetables a day among high school students has not significantly changed.

Percent of High School Students Who Age Fruits or Vegetables Five or More Times Per Day, Past 7 Days

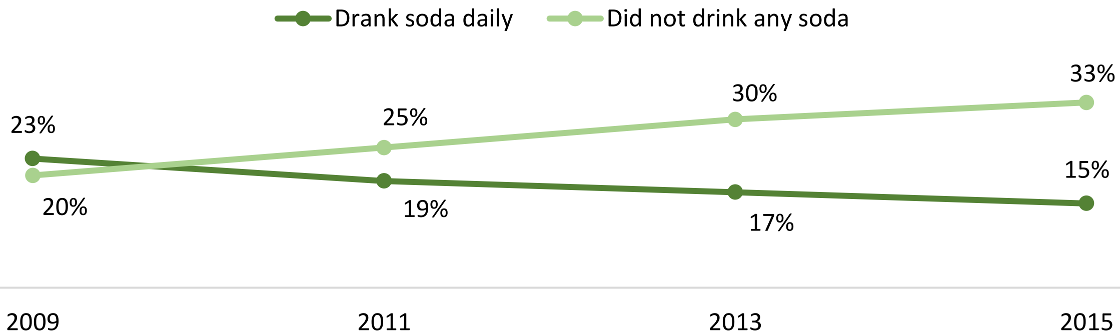


Soda and Sugar-Sweetened Beverage Consumption[εε]

Less than one in five (15%) high school students drink at least one can, bottle, or glass of soda or pop daily. One in ten students drink two or more cans of soda daily. Likewise, a similar proportion reported drinking at least one sugar-sweetened beverage each day (15%) with eight percent drinking two or more sugar-sweetened beverages every day during the past seven day.

Consumption of any soda or sugar-sweetened beverages during the past seven days decreased significantly from 23% in 2009 to 15% in 2015. Correspondingly, the percent of students reporting not drinking any soda or sugar-sweetened beverages in the past seven days significantly increased (20% vs. 33%).

Consumption of Soda and Sugar-Sweetened Beverages by High School Students, Past Week



[ε] *Questions about fruit and vegetable consumption were only asked on the VT High School YRBS*

[εε] *Questions about soda and sugar-sweetened beverages were only asked on the VT High School YRBS*

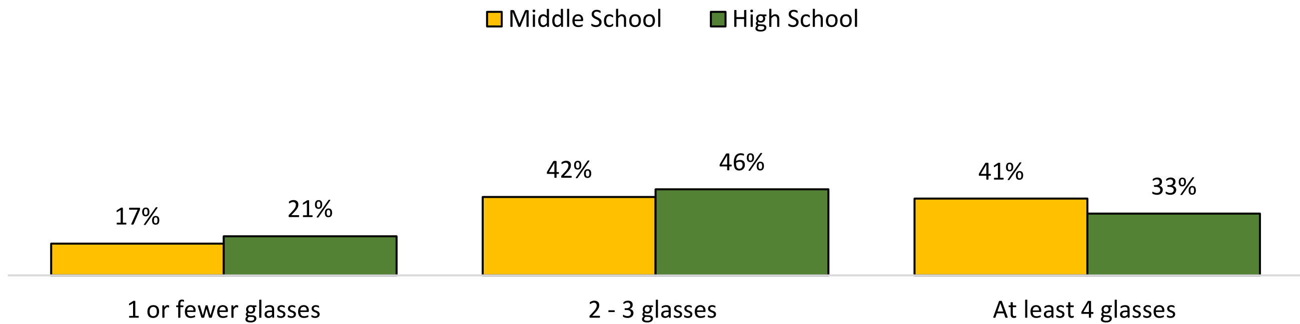
What we know: Water and Breakfast Consumption

2015 Vermont Youth Risk Behavior Survey

Water Consumption

Four in ten middle and a third of high school students drank four or more bottles or glasses of plain water the previous day. However, about one in five middle and high school students drank one or fewer glasses of water during the previous day, with one in ten having no water (7% MS, 9% HS). Consumption of four or more glasses of water increased significantly from 2013 to 2015, for both middle (39% vs. 41%) and high school (30% vs. 33%).

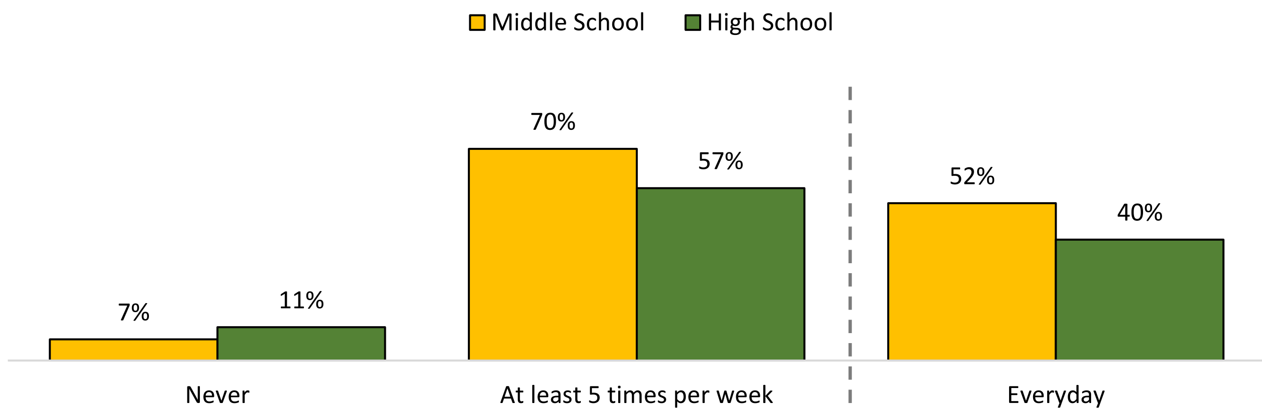
Water Consumption Among Middle and High School Students, Past Day



Breakfast Consumption

Most students eat breakfast at least five times per week. More than half of all middle school students (52%) ate breakfast every day in the past week, and seven in ten ate breakfast on at least five days. Eating breakfast is reported less frequently by high school students. Overall, four in ten of high school students ate breakfast every day, while 57% ate breakfast on at least five days in the last seven. About one in ten middle (7%) and high (11%) school students reported never eating breakfast.

Frequency of Eating Breakfast Among Middle and High School Students, Past 7 Days



What we are doing: Healthy Eating Learning Opportunities

2016 Vermont School Health Profiles

Providing opportunities for students to learn about nutrition and other dietary behaviors helps them develop the knowledge and skills necessary to choose and consume healthy foods. Schools were asked about 20 nutrition and dietary behavior topics identified to help increase knowledge related to diet and nutrition.

Overall, a third of schools taught about all 20-key nutrition and dietary behavior topics. High schools are significantly more likely to teach all 20 nutrition and dietary behavior topics compared to middle schools (48% vs 31%).

Nutrition and Dietary Topics Taught#

Topic	Middle School	High School
Risks of unhealthy weight control	60%	96%
Choosing foods low in added sugar	72%	96%
Choosing foods low in solid fats	72%	96%
Eating more fruits, vegetables, and whole grain products	78%	96%
Balancing food intake and physical activity	76%	96%
Differences between nutritious and non-nutritious beverages	74%	96%
Using food labels	71%	96%
Benefits of eating breakfast every day	79%	96%
Benefits of healthy eating	82%	96%
Accepting body size differences	66%	92%
Eating a variety of foods high in calcium	67%	92%
Benefits of drinking plenty of water	83%	92%
Relationship between diet and chronic conditions	51%	89%
Symptoms of eating disorders	54%	89%
Choosing foods low in sodium	68%	89%
Food guidance using current Dietary Guidelines	81%	89%
Food safety	65%	85%
Preparing healthy meals and snacks	67%	81%
Eating a variety of foods high in iron	61%	81%
Assessing BMI	39%	65%

All differences between middle and high schools are significant

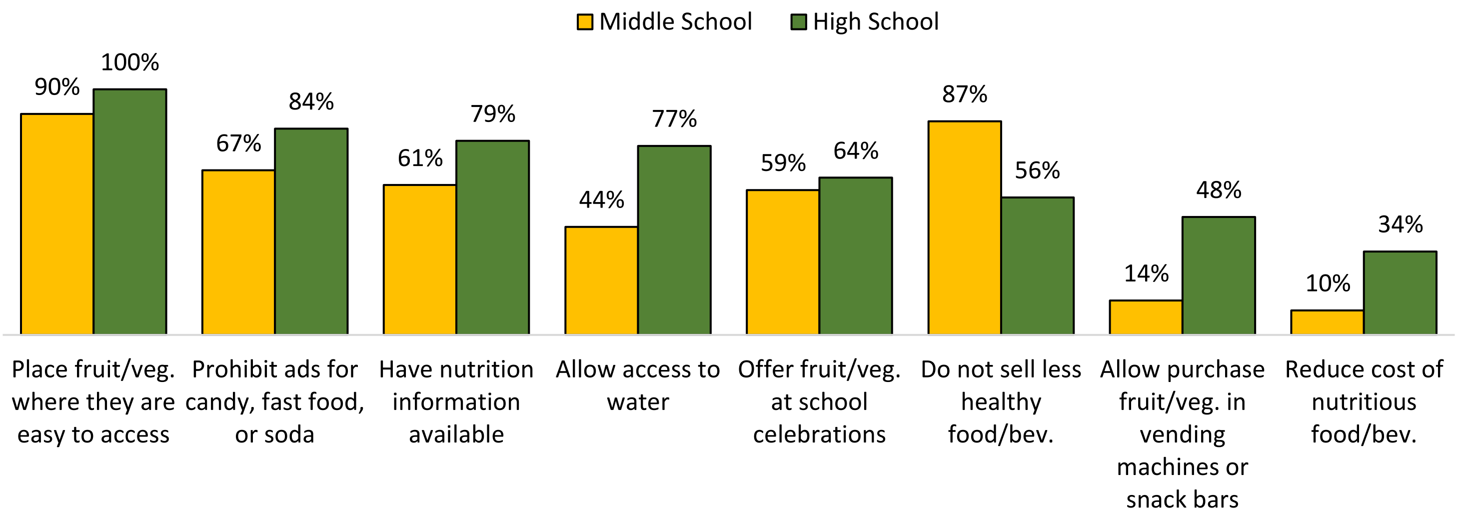
What we are doing: Supportive School Nutrition

2016 Vermont School Health Profiles

The supportive school nutrition environment includes multiple elements related to how schools provide students access to nutritious meals and snacks.[17, 18] These include increasing access to fruits and vegetables including during meal times, at school celebrations and from vending machines or school stores, not allowing advertisements for or selling less healthy foods or beverages, pricing nutritious foods and beverages at a lower cost, and providing nutritional information to students or families.

Overall, more than nine in ten (93%) schools put fruits and vegetables where they are easy to access. About three-quarters do not sell less healthy foods and beverages (74%), or prohibit ads and promotions for candy, fast food, or soft drinks (73%). Six in ten provide nutritional information to students or parents (62%), offer fruits or non-fried vegetables at school celebrations (62%), and allow students access to free water (58%). Less than a quarter allow students to buy fruits and vegetables from vending machines or as a la carte items (24%) or price nutritious foods and beverages at a lower cost (16%). High schools are significantly more likely to include components of a supportive school nutrition environment compared to middle schools.

Percent of Schools Meeting Key Components of a Supportive School Nutrition Environment#



Since 2008 the percent of schools with the following practices have significantly increased: not sell less healthy foods and beverages (39% to 74%), provide nutritional information to students and families (46% to 62%), price nutritious foods and beverages at a lower cost while increasing the cost of less nutritious foods (9% to 16%). Since first asked in 2014, the percent of schools prohibiting advertisements for candy, fast food, or soft drinks also significantly increased (66% to 73%).

All differences between middle and high schools are significant

What we are doing: Supportive School Nutrition

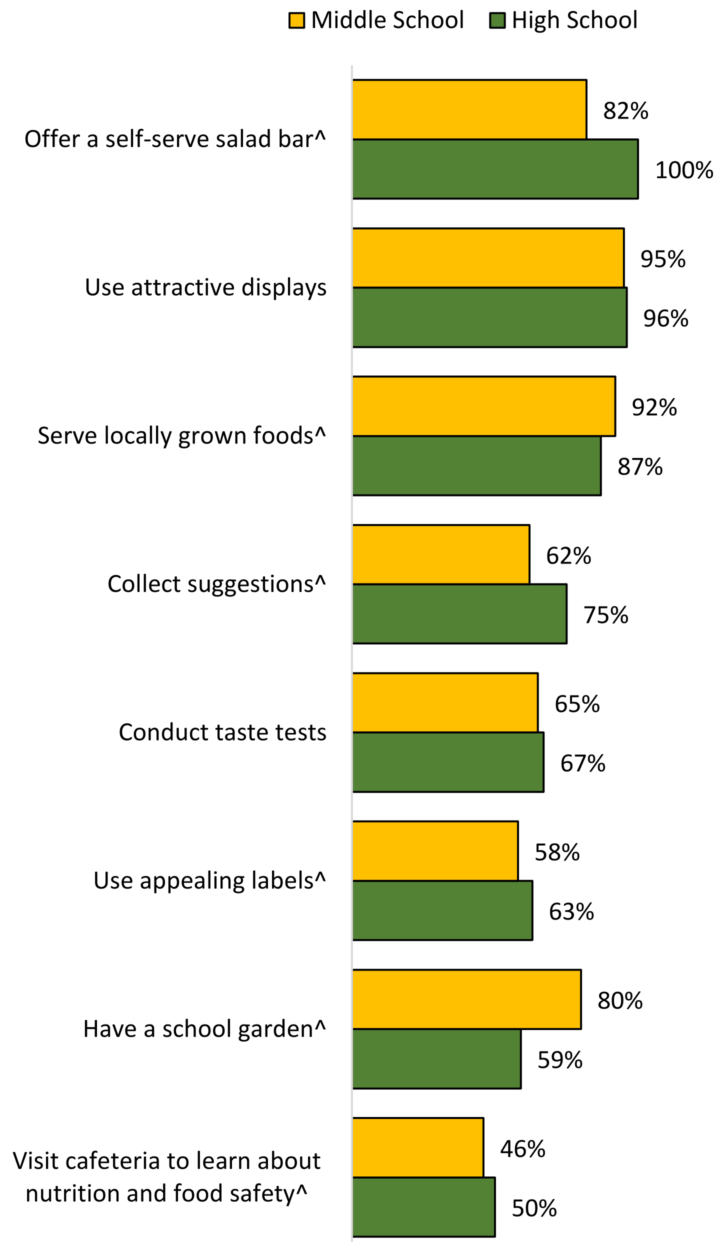
2016 Vermont School Health Profiles

Other methods schools use to promote healthy eating include attractive displays for fruits and vegetables (95%), offering a self-serve salad bar (86%), collecting suggestions on food preferences (69%), conducting taste tests to determine food preferences for nutritious items (63%), and labeling healthful foods with appealing names such as crunchy carrots (56%).

In addition, most schools (92%) serve locally grown foods; three out of four have a school garden (75%).

While high schools are more likely to have a supportive school nutrition environment, middle schools are significantly more likely than high schools to have a school garden and to serve locally grown foods in the cafeteria. Middle and high schools are equally likely to use attractive displays and conduct taste tests.

The percent of schools offering a self-serve salad bar, using attractive displays and appealing labels for fruits and vegetables, and who have a school garden has significantly increased since first asked in 2012 (from 68% to 86%, 50% to 56%, 75% to 95%, and 65% to 75%, respectively). Conducting taste tests and visiting the school cafeteria to lean about food safety, preparation, and nutrition has also increased since 2008 (47% to 63% and 35% to 46%, respectively).



^ *Significant difference between middle and high schools*

Policies, Programs, and Prevention

Nutrition Environment and Services

What we are doing: Smart Snacks

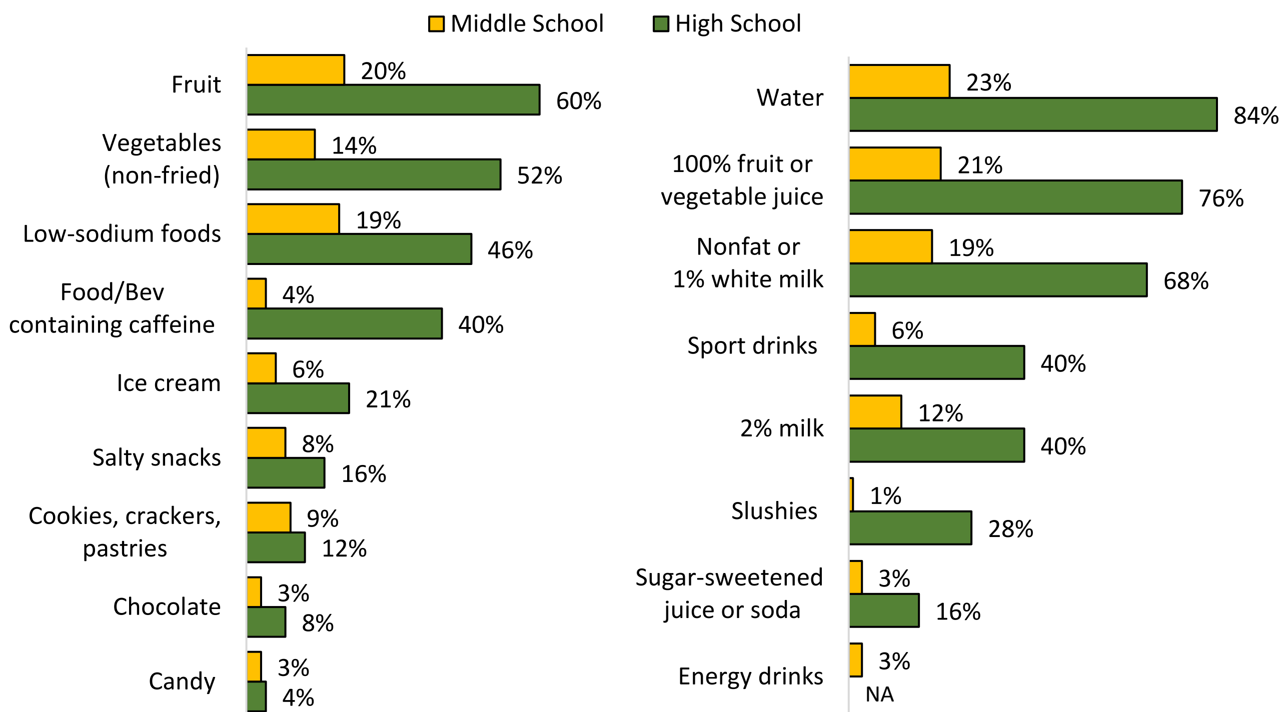
2016 Vermont School Health Profiles

Beginning in the 2014-15 school year, all food sold at school during the school day, including snacks and items sold as fundraisers, is required to meet nutritional standards. Smart Snacks Standards applies to food sold a la carte, in the school stores, and in vending machines.[19]

In 2016, less than half of all schools (46%) had vending machines, school stores, or snack bars available for students to purchase snack foods or beverages food. High schools are nearly three times as likely than middle schools to allow students to purchase foods or beverages from vending machines or school stores (84% vs 29%). Since 2008, the percent of schools with vending machines has significantly decreased from 80%. Between 2014 and 2016, nearly one in ten fewer schools allowed students to purchase foods or beverages from vending machines or school stores (55% vs 46%).

Among all schools, the most commonly available beverages and snacks are bottled water (42%), 100% fruit or vegetable juice (38%), non-fat or 1% milk (32%), fruit (31%), low or no added sodium crackers/chips (28%). A quarter or fewer schools had the following available at vending machines, school stores, or snack bars: vegetables (24%), sports drinks (21%), two percent or whole milk (19%), caffeinated drinks/snacks (13%). One in ten or fewer schools sold the following: baked goods (10%), salty snacks (10%), soda or sugar-sweetened beverages (9%), ice cream (8%), slushies (8%), chocolate (5%), candy (4%), and energy drinks (2%).

Percent of schools selling food and beverages in vending machines, school stores, or snack bars*, #



** Includes schools with and without vending machines, school stores, and snack bars. Schools without vending machines, school stores, and snack bars are counted as not selling foods and beverages.*

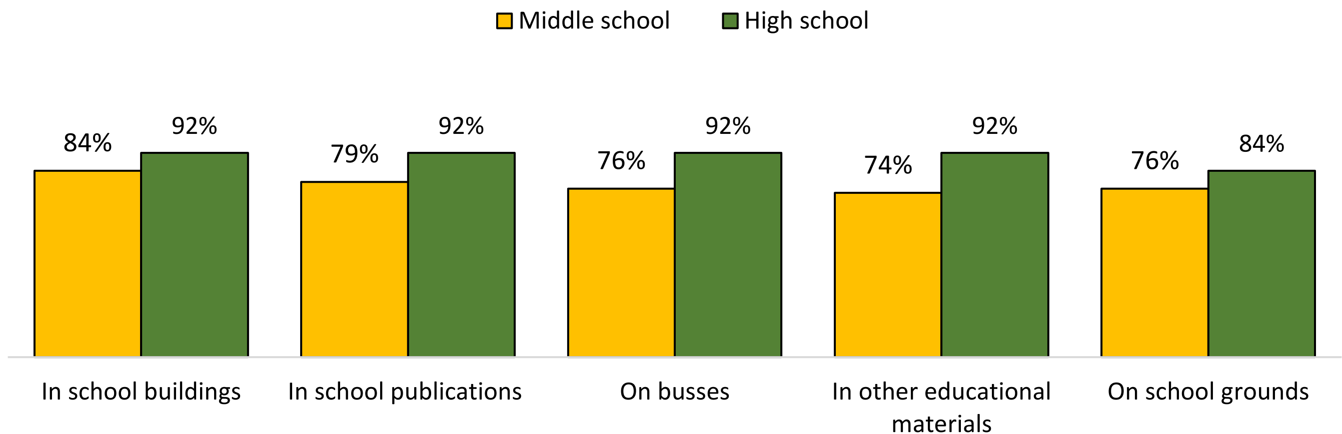
 # All differences between middle and high schools are significant

What we are doing: Marketing, Celebrations and Rewards

2016 Vermont School Health Profiles

Marketing with Foods and Drinks

Most schools (73%) prohibit all forms of advertisements for candy, fast food restaurants and soft drinks at their school. Overall, schools are most likely to prohibit advertisements in school buildings (85%) than in school publications (82%), on school busses or other school vehicles (80%), in curricula or on other educational materials such as school supplies and electronic media (79%), or on school grounds such as playing fields (79%). High schools are significantly more likely than middle schools to ban such advertisements.



In 2016, fewer schools allowed advertisements for candy, fast food, and soda compared to those in 2008. Since first asked, the percent of schools prohibiting advertisements has significantly increased in the following locations: school buildings (68% to 85%), on school grounds (65% to 79%), on school busses (69% to 82%), in school publications (70% to 82%), and in other educational material (72% to 79%).[ε]

Using Food and Drinks as Rewards and in School Celebrations

Nearly half of all schools prohibit the sale of candy and baked goods for fundraisers (47%). Less than a third prohibit staff using food or food coupons as a reward (35%). When hosting school celebrations, nearly all schools offer foods and beverages. More than six in ten schools always or almost always offer fruits or vegetables and few rarely do so (2%).

High schools are significantly more likely to always or almost always prohibit candy and baked good for fundraisers (62%), use foods as a reward (39%), and offer fruits and vegetables at celebrations (64%), compared to middle schools (43%, 29%, and 59%, respectively).

The percent of schools prohibiting the sale of candy and baked good for fundraisers more than doubled from 25% in 2014 to 47% in 2016. The percent of schools not allowing students food as a reward has also increased, from 27% in 2014 to 35%. Since 2008 the percent of schools offering fruits and vegetables during school celebrations significantly increased from 37% to 62%, however, there was no change between 2014 and 2016.

[#] *All differences between middle and high schools are significant*

[ε] *Questions about advertisement in other school material was first asked in 2014; all other locations were first asked in 2008*

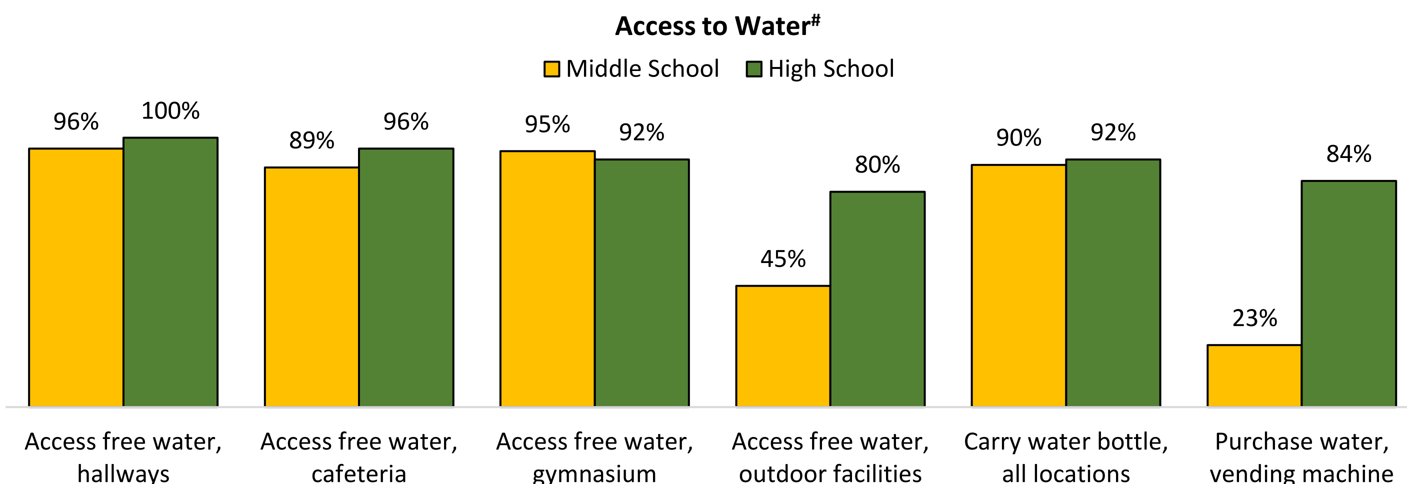
What we are doing: Access to Water

2016 Vermont School Health Profiles

In 2016, more than nine in ten (93%) of schools encouraged students to drink water throughout the day. Nearly all schools provide drinking water in hallways throughout the school (98%), while most also offer a source of free water in the gymnasium (94%), during lunch (92%), and during breakfast (91%). Fewer schools provide access to water in outdoor physical activity facilities and sport fields (61%).

High schools are more likely than middle schools to provide access to water in all of these locations. Most notably, 80% of high schools provide students access to water in outdoor facilities compared to less than half of middle schools. However, this difference may have to do more with differences in facilities available in the schools than differences in policies.

In addition, nearly all schools (99%) permit students to carry water bottles with them during the day. Ninety-one percent permit water bottles in all locations, while less than one in ten (7%) only permit water bottles in some locations and 2% of schools do not allow students to carry a water bottle with them during the day.



Overall, since first asked in 2014, the percent of schools that allow students access to water has significantly increased (46% vs 58%). Specifically, access to water in outdoor facilities and in the cafeteria during breakfast or lunch significantly increased from 54% to 61% and from 88% to 91% and 89% to 92%, respectively.

All differences between middle and high schools are significant

Policies, Programs, and Prevention

Sexual Health

Many young people engage in sexual health behaviors that put them at risk for HIV infection, STDs, and unintended pregnancies.[20] While sexual risk behaviors among young people (including HIV transmissions and unintended pregnancies) have declined since the early 1990's, progress has stalled in recent years.[21] Risky sexual health behaviors among youth in the United States remain substantially higher than other western industrialized nations. [22, 24] Youth, aged 15 to 19, accounted for nearly 22% of new HIV diagnoses in the United States in 2015 and nearly 250,000 births in 2014. [22, 23]

Sexual health is more than the absence of disease and dysfunction.[24] It includes the state of physical, emotional, mental and social well-being. Schools play a critical role in facilitating preventative services, providing youth with the knowledge and skills needed to take responsibility for their health. [24] Sexual health education should be developmentally appropriate for students in grades K-12 including those who are and are not sexually active, as well youth of all sexual and gender identities.

Exemplary Sexual Health Education (ESHE) is a systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions that provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STD, and unintended pregnancy.[22] While abstinence is the only 100% effective way to prevent HIV, other STDs, and pregnancy,[26] there is no evidence that abstinence-only sexual education programs are effective or provide the tools necessary for young people to protect themselves from negative health outcomes.

Exemplary Sexual Health Education Programs

Key Features	Supported Outcomes
▪ Medically accurate ▪ Based on scientific evidence ▪ Developmentally appropriate ▪ Inclusive of all youth regardless of gender or sexual orientation ▪ Comprehensive classroom instruction that focuses on increasing student knowledge, developing critical skills, and practices and attitudes needed to avoid negative health outcomes ▪ Expands beyond classroom instruction to include access to sexual health services, on and off school property	▪ Delayed onset of sexual activity ▪ Reduced frequency of sexual activity and number of sexual partners ▪ Increased use of condoms and highly effective contraceptives ▪ Decreased rates of teen pregnancies, STD's and HIV infections ▪ Increased use of sexual health services

In 2013, the Vermont Agency of Education (AOE) received a five-year grant from CDC's Division of Adolescent and School Health to deliver exemplary sexual health education emphasizing pregnancy, HIV and other STD prevention.[25] Specifically, AOE works with local districts and schools to assess curricula and expand exemplary sexual health education programs, to develop or revise their sexual health services policy, develop a referral system if services are not offered on site, and reduce stigma and discomfort by providing students with additional health care resources, and to provide development and technical assistance to districts to improve school climate for all students. Based on YRBS and other data sources, AOE used chose to focus their efforts on LGBT Youth as a population at disproportional risk. This grant has provided districts with professional development on LGBT issues and support for Gay Straight Alliances at middle and high schools.

Policies, Programs, and Prevention

Sexual Health

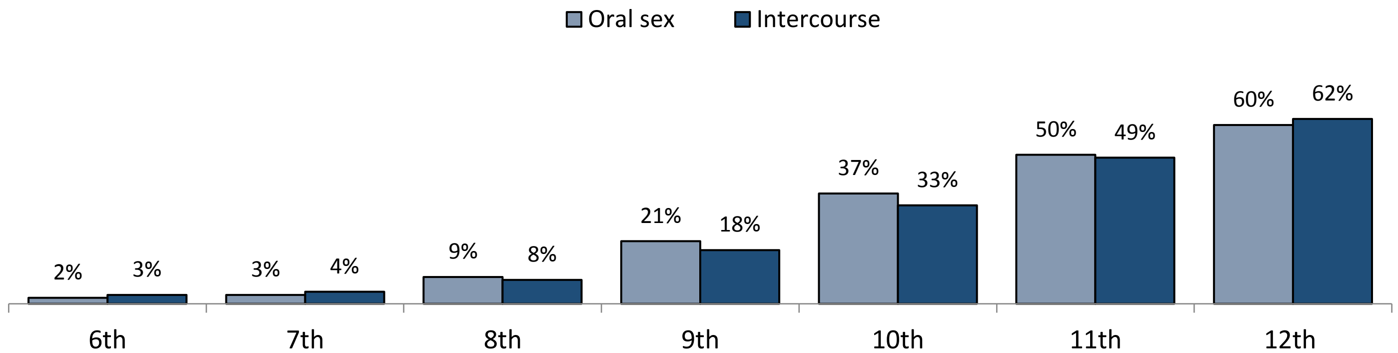
What we know: Sexual Behaviors

2015 Vermont Youth Risk Behavior Survey

In 2015, six percent of middle school students reported having sexual intercourse during their lifetime. One in twenty have had oral sex. More than four out of ten high school students have had sexual intercourse (41%) or oral sex (42%) during their lifetime. The percent of students who reported ever having sex increases significantly with each grade.

Since 2013, the percent of high school students ever having oral sex and ever having sexual intercourse decreased significantly from 44% and 43%, respectively. Lifetime sexual activity was first asked among middle school students in 2015; no additional questions about current sexual activity, number of partners or other sexual behaviors were asked of middle school students.

Lifetime Oral and Vaginal Intercourse Among Middle and High School Students



What we know: STD and Pregnancy Prevention Among High School Students

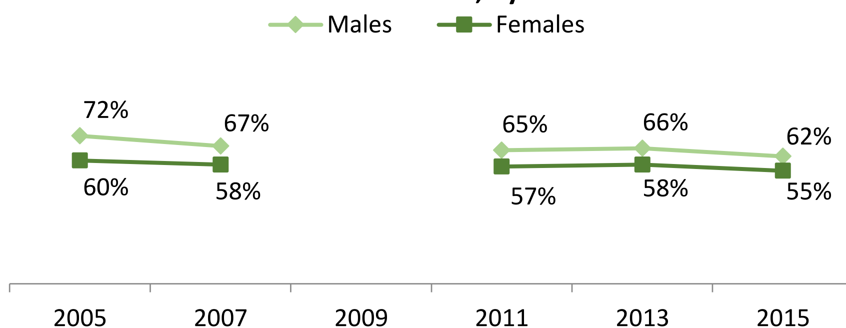
2015 Vermont Youth Risk Behavior Survey

In the past three months, nearly one third (31%) of high school students reported having sex. However, only 58% of those students reported using a condom during their most recent sexual experience. Less than one in five sexually active students used both a condom and prescription birth control during their most recent sexual intercourse to prevent unintended pregnancies. Thirteen percent did not use either a condom or an effective form of birth control.

Condom use during their most recent sexual experience and as the primary pregnancy prevention method used is significantly higher among male students (62% and 45%, respectively) compared to female students (55% and 31%, respectively).

Among sexually active students, about half (47%) use a moderately or highly effective form of birth control such as birth control pills, patch, shot, ring, implant or IUD as their primary method to prevent pregnancy.

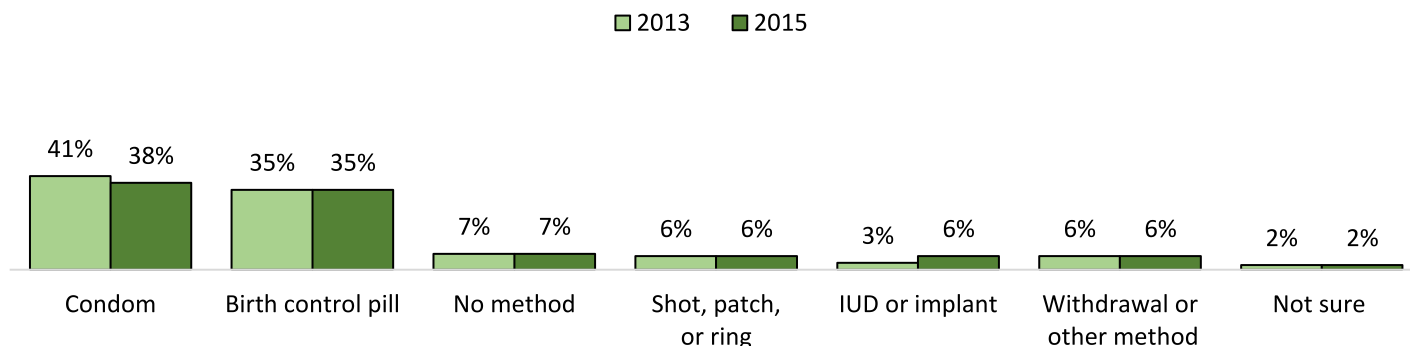
Sexually Active High School Students Using a Condom at Last Intercourse, By Sex[2]



Female students are significantly more likely than males to report using moderately or highly effective forms of birth control (55% vs 38%). Most notably, twice as many females use a shot, patch, or vaginal ring (8% vs 4%) or an IUD or implant (8% vs 4%).

Since 2013, the percent of high school students who are currently sexually active has decreased significantly (33% vs 31%). Condom use during students' most recent sexual experience (62% vs 58%) and the use of condoms to prevent pregnancy (41% vs 38%) both significantly decreased from 2013 to 2015. Use of moderately or highly effective prescription birth control to prevent unintended pregnancies significantly increased from 44% in 2013 to 47% in 2015.

Primary Method of Pregnancy Prevention Used Among Sexually Active High School Students



[2] NOTE: sexual activity during the past 3 months was not asked in 2009

Policies, Programs, and Prevention

Sexual Health

What we are doing: Teaching Exemplary Sexual Education

2016 Vermont School Health Profiles

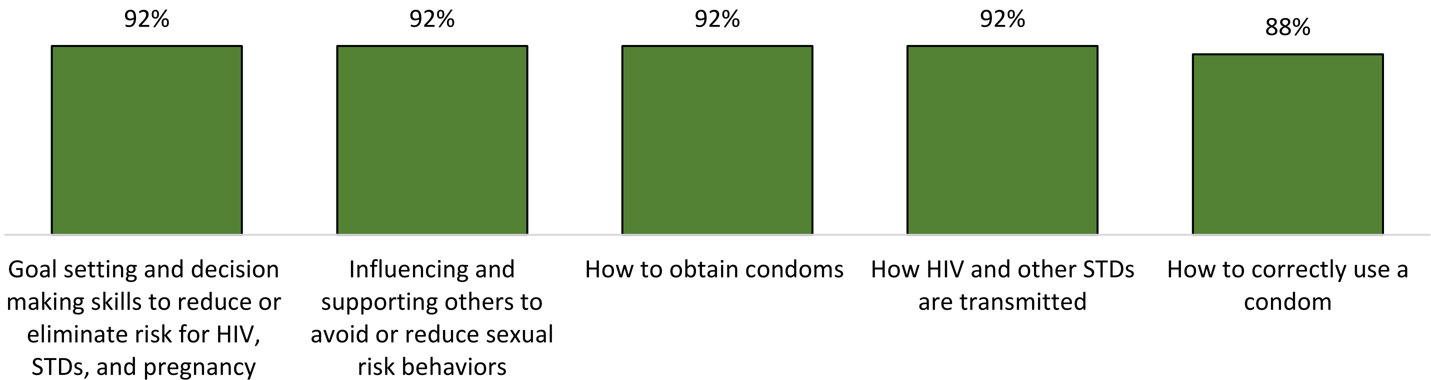
Lead health educators were asked about 19 sexual health topics taught in required health education courses and the assessment of student's competence in seven of those topics. These questions were asked specifically about courses in 6th through 8th grades and in courses in 9th through 12th grade.

Schools with students in grades 9 through 12 are nearly four times as likely to teach all 19 sexual health topics compared to schools teaching students in grades 6 through 8 (79% vs 21%) and are two times as likely to assess students' ability to understand and perform all seven skills (74% vs 37%)

Sexual Health Education in Grades 9 -12

All sexual health topics, except how to correctly use a condom (88%), were taught by more than nine in ten high schools, during the past year. Nearly all (96%) high schools taught about the benefits of abstinence, efficacy of condoms, the importance of using condoms consistently and correctly, methods of contraception other than condoms, dual use of condoms and contraceptives, limiting the number of sexual partners, preventative care, the health consequences of HIV, STDs, and unintended pregnancy, how to access valid and reliable sexual health information and services, creating healthy relationships, communication skills, gender roles, identity, or expression, sexual orientation, and the influence of family, peers, and society on sexual health behaviors.

Five *least* commonly taught sexual health topics among high schools, grades 9-12

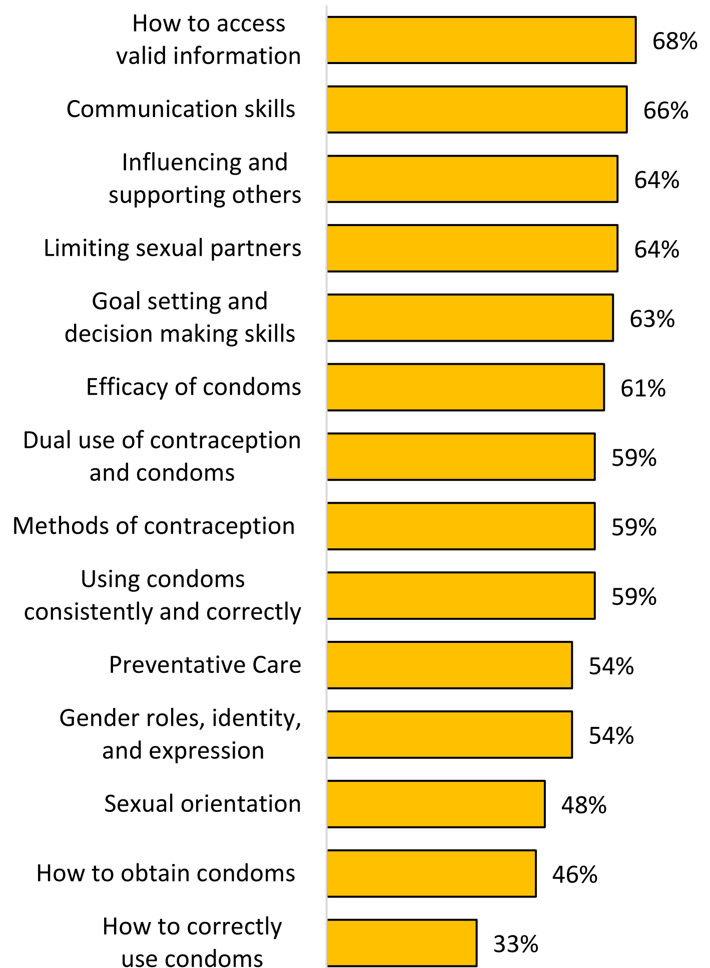


In the past year, nearly all high schools (96%) assessed student's ability to comprehend key concepts, analyze the influence of others, and set personal goals that enhance health and monitor one's progress. Most (88%) assessed student's ability to use decision making skills to prevent HIV, STDs, and pregnancy, access valid information, products, and services related to sexual health, and to use interpersonal communication skills to reduce sexual risk behaviors. Three-quarters of high schools assessed student's ability to influence and support others in reducing sexual health risk behaviors.

Sexual Health Education in Grades 6-8

Three-quarters or fewer middle schools covered any sexual health topics during the past year. Middle schools were most likely to address how HIV and STDs are transmitted (75%), family, peer and societal influences on sexual risk behaviors (74%), the benefits of being abstinent (73%), health consequences of HIV, STDs, and unintended pregnancies (71%). Less than half taught about sexual orientation (48%), how to obtain condoms (46%), and how to correctly use condoms (33%). Sexual health topics covered by less than seven in ten schools are shown to the right.

In the past year, about six in ten middle schools assessed student's ability to use interpersonal communication skills to reduce sexual risk behaviors (63%), analyze the influence of others (60%), use decision making skills to prevent HIV, STDs, and pregnancy (59%) and their comprehension of key concepts (59%). About half of all middle schools assessed student's ability to access valid information (54%), influence and support others in reducing sexual health risk behaviors (52%), and setting personal goals that enhance health (52%).



ESHE Key Topics Taught in Middle and High Schools

Eleven of the 19 sexual health topics included on the School Health Profiles have been identified as key components of exemplary sexual health education. The 11 topics include: how to create and sustain healthy and respectful relationships, communication and negotiation skills and goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STD, and pregnancy, benefits of being sexually abstinent, the importance of limiting the number of sexual partners, using condoms consistently and correctly, and dual use of birth control and condoms, preventive care such screenings and HPV immunizations, influences of family, peers, culture, media, technology and other factors on sexual risk behaviors, influencing and supporting others to avoid or reduce sexual risk behaviors, and how to access valid and reliable health information, products, and services related to HIV, other STD, and pregnancy.

Overall, 87% of high schools taught all 11 key topics in a required course during grades 9-12, and 34% of middle schools taught 11 key topics in a required course in grades 6-8. Schools with students in both middle and high school grades did not cover these topics in both grade levels.

What we are doing: Sexual Health Services

2016 Vermont School Health Profiles

Three-quarters of all schools do not provide any sexual or reproductive health services on school property, nearly half (49%) do not provide referrals for any sexual health services. Key sexual health services include: HIV testing, STD testing pregnancy testing, provision of condoms, provision of condom-compatible lubricants (i.e., water- or silicone-based), provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, IUD), and human papillomavirus, or HPV vaccination. High schools are more likely than middle schools to provide key sexual health services, either directly or by referral (70% vs 20%).

Direct Services Provided on School Property for Sexual Health Services

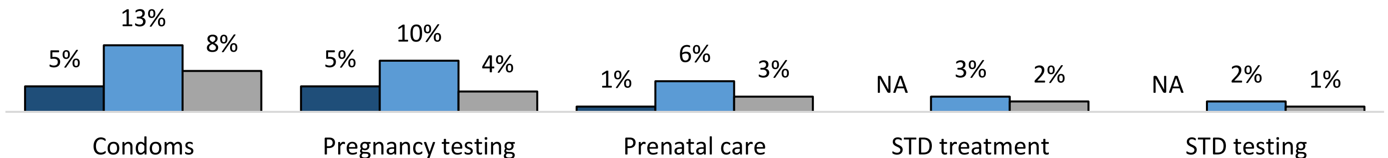
Overall, less than one in ten schools provide direct sexual health services on school property. The most common direct sexual health services schools provide are the provision of condoms (8%), condom-compatible lubricants (5%), pregnancy testing (4%) and prenatal care (3%). Less than two percent of schools provide other sexual health services.

Excluding prenatal care (1%), no middle schools provide direct sexual health services for students. Among high schools, direct services are most frequently related to the procurement of condoms (13%), condom-compatible lubricants (12%), and STD treatment (8%). Less than five percent of high schools provide other services related to sexual health.

Provision of contraceptives and condoms, providing pregnancy testing, prenatal care, and HIV testing, and administration the HPV vaccine were first asked in 2012, direct services for other sexual health were first asked in 2014. Interestingly, the percent of schools offering direct services significantly increased between 2012 and 2014 and then decreased between 2014 and 2016 for the following: pregnancy testing (5% to 10% to 4%), provision of condoms (5% to 13% to 8%), and prenatal care (1% to 6% to 3%).

Significant Changes in Sexual Health Services Directly Porvided by Schools

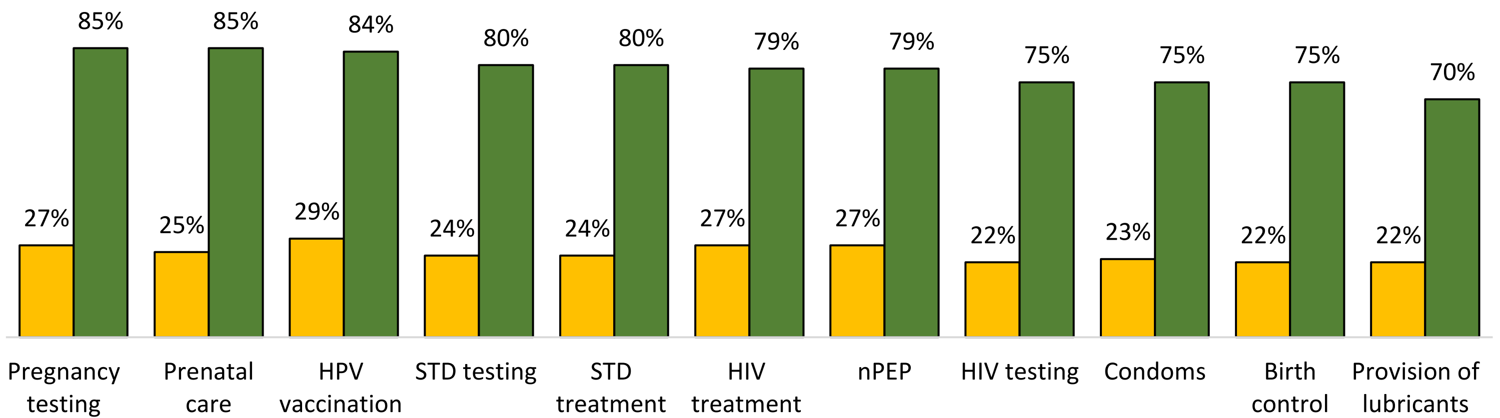
2012 2014 2016



What we are doing: Sexual Health Services
2016 Vermont School Health Profiles

Referrals to Community Providers for Sexual Health Services
Referrals for students to any organization or health care professional for sexual health related services are provided by about eight in ten high schools and less than three in ten middle schools. High schools were nearly three times as likely to provide referrals for sexual health services.

Schools Providing Referrals for Sexual Health Services#



Since first asked in 2014, significantly fewer schools provided referrals for students to get tested for STDs (53% to 44%), STD treatment (52% to 43%), and HIV treatment (53% to 46%). Referrals to community health care professionals off school property also decreased since first asked in 2012 for HIV testing (56% to 42%), HPV vaccine administration (53% to 28%), pregnancy testing (58% to 47%), provision of birth control (47% to 42%), and prenatal care (51% to 46%).

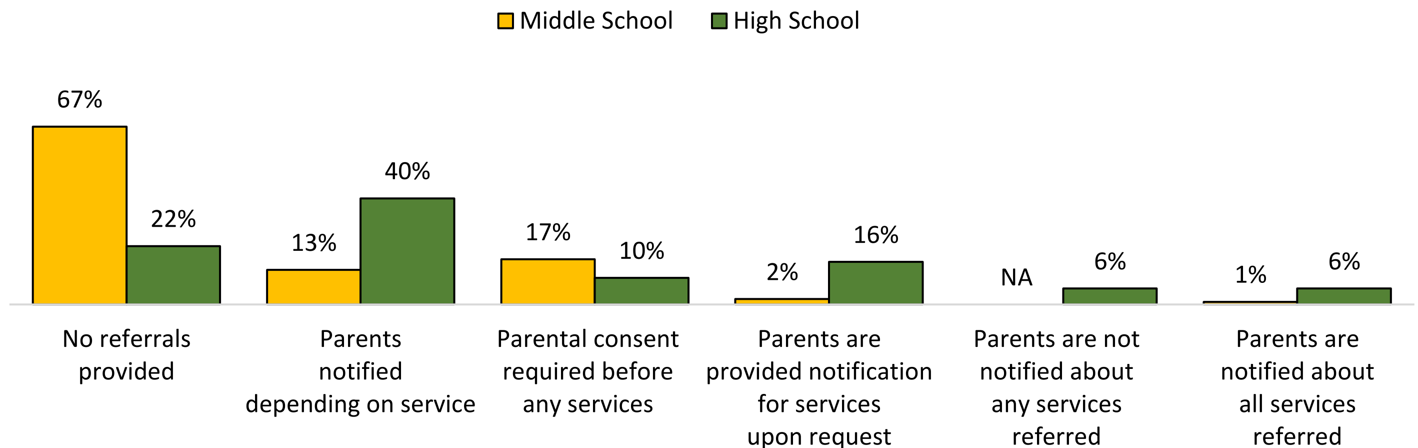
All differences between middle and high schools are significantly different

What we are doing: Sexual Health Services

2016 Vermont School Health Profiles

When sexual health services are provided, directly or indirectly, communication with parents or guardians ranges from requiring parental consent before any services are provided to the notification of services provided to no parental consent needed.

When schools provide referrals for sexual health services to off-site providers nearly a quarter (23%) do not require parental consent, but notification may be provided depending on the service referred. One in seven (14%) schools require parental consent before providing a student with any referral for sexual health services. Six percent of schools provide parents with information about services referred only upon request or do not notify the parents of the services provided. Three percent of schools notify a parent about all referrals. The type of parental consent or notification for referrals to sexual health care providers, shown below, significantly differed among middle and high schools.[#]



Communication with parents about sexual health services provided on campus followed a similar pattern to services referred off school property. Three quarters of schools (76%) do not provide any direct sexual health services, eight percent of schools require parental consent before any services are provided. Other schools notify parents depending on the type of service provided (8%), provide parents with information only upon request (3%), do not notify parents about any services provided (3%), or do not require parental consent but notify parents of all services provided (2%).

Among high schools, the most common policy regarding notification of provision of direct sexual health services is notification of parents depending on the type of service provide (22%). Requiring parental consent before any sexual health services are provided (9%) is the most common among middle schools.[##]

[#] *All differences are significantly different between middle and high schools*

[##] *Notification of sexual health services on school property also varied significantly between middle and high schools*

Policies, Programs, and Prevention

Safe and Inclusive Environments

While eliminating or reducing risk behaviors is important for youth development, increasing protective factors may play a greater role in youth development and success later in life.[26] Assets or protective factors often reduce multiple risky behaviors and promote social and emotional development in all areas of one's life.

Positive Youth Development (PYD) is an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.[27, 29]

PYD involves and engages the entire community.[27] It enhances the sense of belonging and creating strong relationships with peers, friends, and those in the community including people of difference backgrounds, cultures, or lifestyles.

Partnerships between schools, families, and communities play an integral role in school's capacity to improve the development, health, and well-being of youth.[29] Schools can create positive school environments which are associated with lower prevalence of substance use, violence, less stigma and discrimination and fewer absences.

http://healthandlearning.org/bullying-and-harassment-prevention/

Suggested policies and practices include not allowing bullying, harassment, or violence against any student, identifying "safe spaces", encouraging student-led clubs that promote school connectedness and a safe, welcoming, and accepting school environment for all students (e.g. gay/straight alliances), ensure health and educational materials include information relevant to all students and use inclusive terms, increase access for students to community-based health care providers, and promote family and community engagement through outreach efforts.

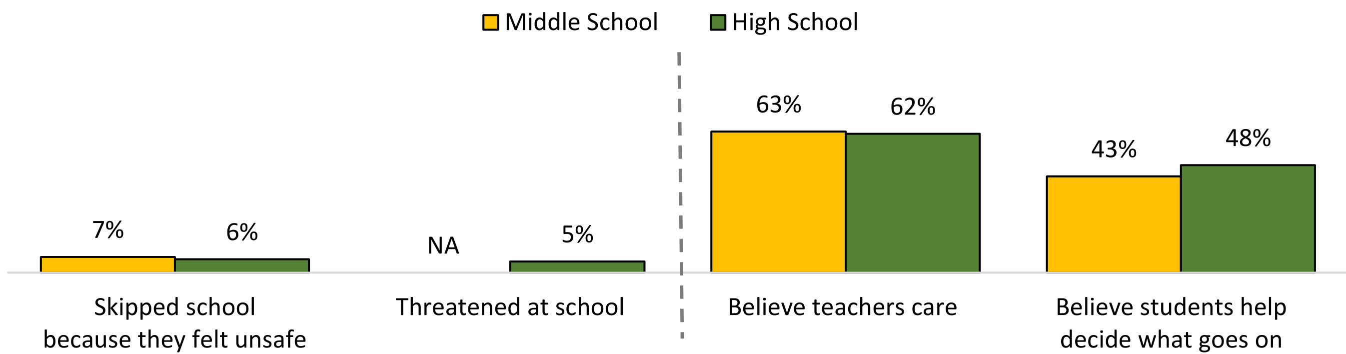
The Vermont Agency of Education believes teaching and learning begins with all students and adults feeling safe, welcome, respected, and supported while at school.[28] Healthy and inclusive learning environments should be free of bullying, sexual harassment, prejudice, and discrimination. These non-threatening but challenging learning environments foster student development and reduce health-risk behaviors and negative disciplinary actions.

What we know: Perceptions of the School Environment

2016 Vermont School Health Profiles

In 2015, less than one in ten middle school (7%) and high school (6%) students did not go to school during the past 30 days because they felt unsafe at school or on their way to or from school. Five percent of high school students have been threatened or injured with a weapon on school property during the past 12 months.

Nearly two-thirds of all students believe their teachers care and give them a lot of encouragement and about half think students help decide what goes on in their school. Specifically, more than six out of ten middle and high school students agreed or strongly agreed that their teachers really care about them and give them a lot of encouragement (63% and 62%, respectively). About four in ten middle school (43%) and five in ten high school students (48%) agreed or strongly agreed that students help decide what goes on in school.



The percent of students skipping school because they felt unsafe significantly increased from 2011 to 2015 among middle school students (6% vs. 7%) and since 1995 among high school students (4% vs 6%). Being threatened at school significantly decreased among high school students since 1995 (7% vs 5%). No changes in these measures were reported from 2013 to 2015.

Perception of one's school has not changed over time among middle school students. In 2015 high school students were significantly more likely to believe their teachers care and encourage them and that students help decide what does on in school compared to 2013 (59% and 47%, respectively).

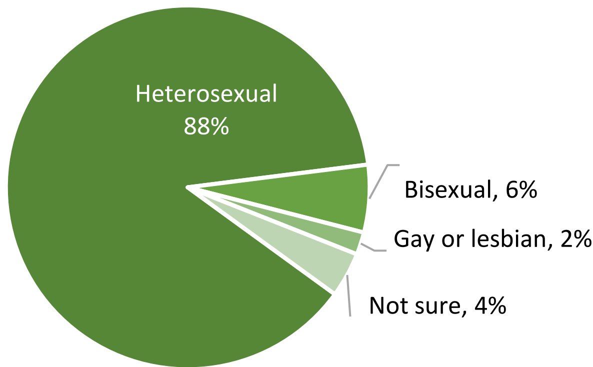
What we know: Sexual Minority Youth

2016 Vermont School Health Profiles

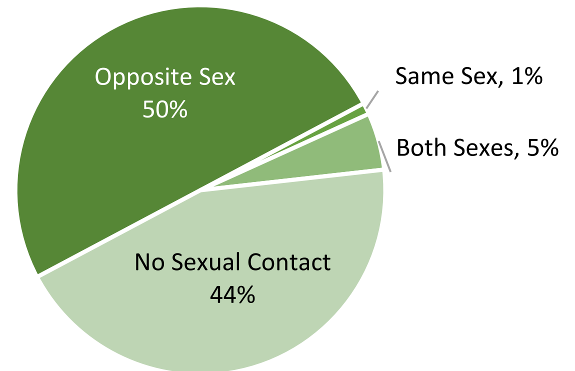
Sexual identity and sex of sexual contacts can both be used to identify sexual minority youth.[29] Vermont has included questions on the YRBS related to sex of sexual contacts since 1997 and on sexual orientation since 2005. These questions have not been asked among middle school students.

Results from the first national representative study on lesbian, gay, and bisexual (LGB) youth results from the YRBS show that nationwide, approximately 1.3 million high school youth identified themselves as LGB.[30] In Vermont, two percent of high school students describe themselves as gay or lesbian, six percent as bisexual, and four percent as not sure. One in two students have had sexual contact only with someone of the opposite sex, one percent have had contact with someone of the same sex, and five percent have had contact with both sexes. More than four in ten high school students have not had any sexual contact.

Sexual Identity Among High School Students

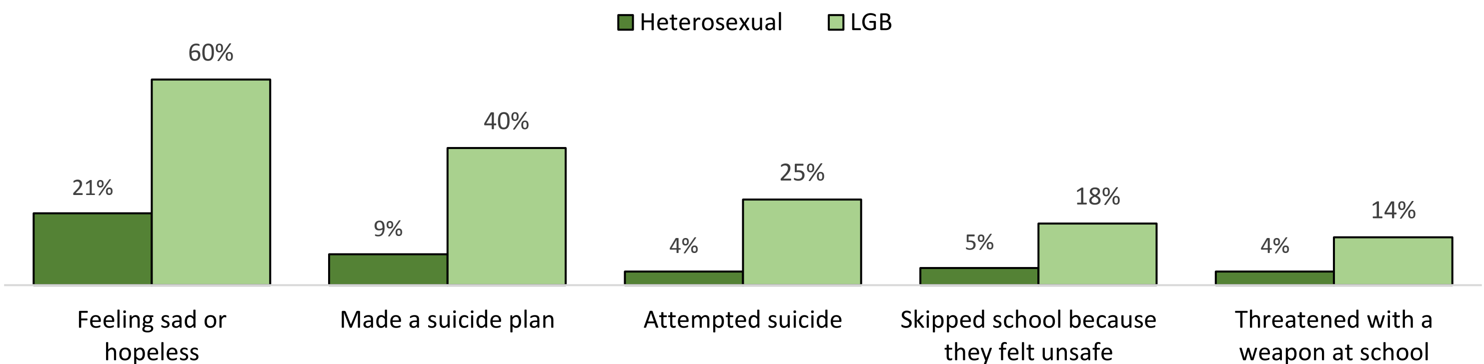


Sexual Contacts Among High School Students



Sexual minority youth are at risk for certain negative health outcome and may struggle with stigma, discrimination, family disapproval, social rejection, and violence.[30] Compared to heterosexual students, LGB youth have higher prevalence of many risk behaviors such as physical and sexual violence, and bullying, suicide, depression and addiction and are more likely to be threatened and skip school because they feel unsafe.

Risk Behaviors and Negative Experiences Among Heterosexual and LGB High School Youth



Policies, Programs, and Prevention

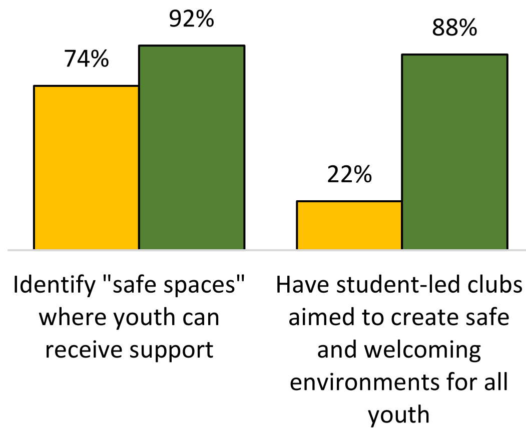
Safe and Inclusive Environments

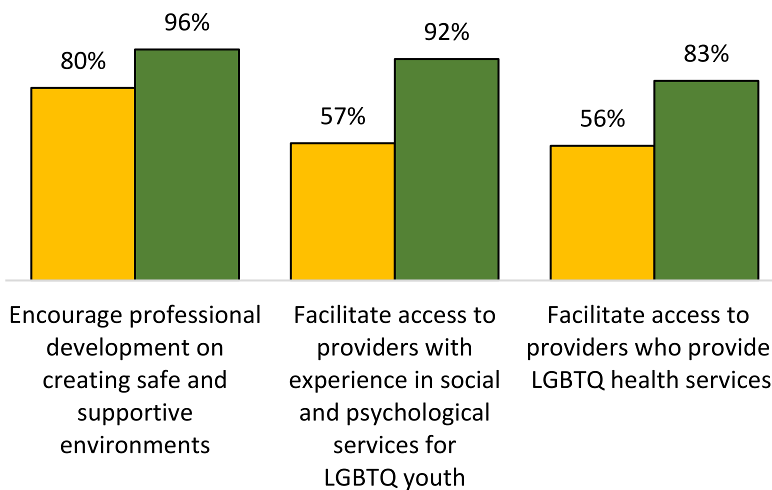
What we are doing: Creating Safe and Inclusive Environments for LGBTQ Youth

2016 Vermont School Health Profiles

In Vermont, nearly all schools prohibit harassment based on a student's perceived or actual sexual orientation or gender identity (99%), a significant increase from 96% in previous years.

Policies and Practices Related to Creating Supportive School Envionments for LGBTQ Youth#





Eight in ten schools identify "safe spaces" where LBGTQ youth can receive support from administrators, teachers, or other school staff and encourage staff to attend professional development related to creating a safe and supportive school environment for all youth regardless of sexual orientation or gender identity.#

Seven in ten schools facilitate access to providers who have experience in providing health services, including HIV/STD testing and counseling and who have experience in providing social and psychological services to LGBTQ youth.

Fewer schools (46%) have student-led clubs aimed to create a safe, welcoming, and accepting school environment for all youth regardless of sexual orientation or gender identity. Notably, four times as many high schools have student led clubs than middle schools.

Since first asked in 2010, policies and practices related to LGBTQ youth have significantly increased. These include: identification of safe spaces (67% to 80%), encouraging staff to attend professional development related to safe and supportive environments (80% to 83%), facilitation of access to providers with experience providing health services (62% to 71%) and social and psychological services (54% to 69%) to LGBTQ youth. Since first asked in 2008, the percent of schools offering student-led clubs doubled from 23% to 46%.

Facilitating access to providers and encouraging professional development for staff did not significantly change between 2014 and 2016.

All differences are significantly different between middle and high schools

Policies, Programs, and Prevention

Safe and Inclusive Environments

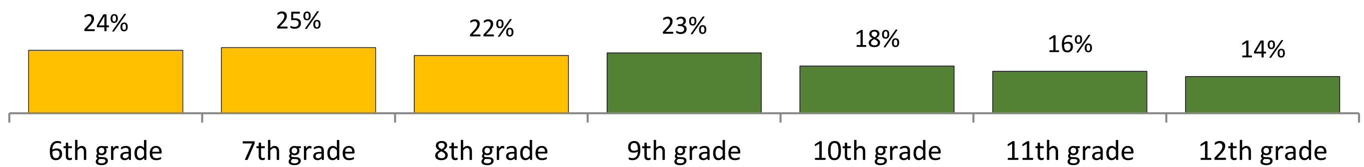
What we know: Bullying

2016 Vermont School Health Profiles

Unlike many other risk factors, bullying tends to decrease with year in school and is more likely to occur among female students. Nearly a quarter (24%) of middle school students and 18% of high school students reported being bullied during the past 30 days.

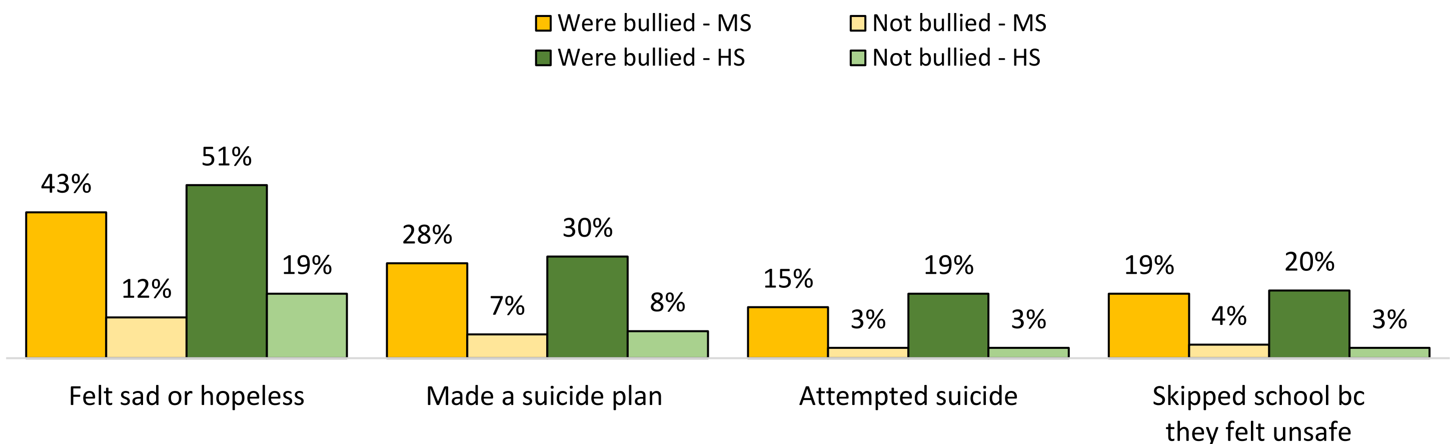
In both middle and high school, female students experience bullying at nearly twice the rate of male students (middle school: 30% vs. 18%; high school: 23% vs 12%). One in five middle school students and three in ten high school students were bullied on six or more days in the past month.

Percent of Students who Reported Being Bullied During the Past 30 Days, by Grade



Bullying can happen anywhere and to anyone, however, some groups, such as LGBTQ youth, transgender youth, socially isolated youth, over- or under-weight, or those who are perceived weak, different, less popular, or have low self-esteem.[30] Youth who are bullied tend to have more depression, anxiety, suicidal ideations, drug and alcohol use, and lower academic achievement.

Risk Factors Among Students Who Were and Were Not Bullied#



All differences between students who were bullied and not bullied in the past 30 days are significant

Policies, Programs, and Prevention

Safe and Inclusive Environments

What we are doing: Creating Safe and Inclusive Environments
Bullying Prevention and Cultural Awareness

2016 Vermont School Health Profiles

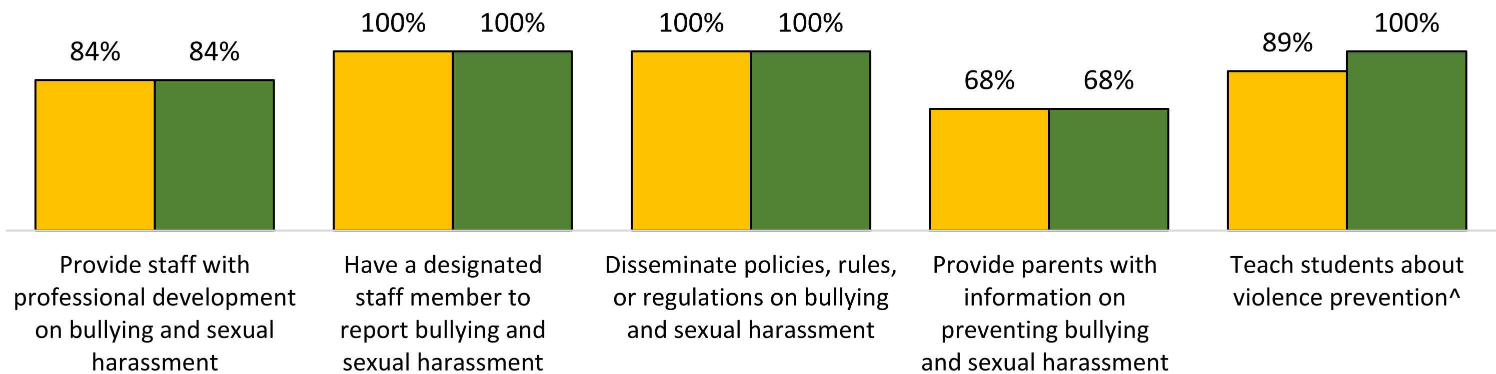
Bullying and Sexual Harassment Prevention

In Vermont, all schools have a designated staff member to whom students can confidentially report student bullying and sexual harassment. Almost all schools use electronic, paper, or oral communication to publicize and disseminate policies, rules, regulations on bullying and sexual harassment, including electronic aggression (99%).

Most schools teach students about bullying, fighting, and dating violence prevention (92%) and provide staff with professional development on preventing, identifying, and responding to student bullying and sexual harassment (86%). About two-thirds provide parents with information and resources preventing student bullying and sexual harassment, including electronic aggression (65%).

Bullying and sexual harassment policies and prevention strategies were equally provided for by middle and high schools except for teaching students about violence prevention. Middle schools are significantly less likely than high schools to teach students about violence prevention including bullying, electronic aggression, fighting, and dating violence (89% vs. 100%).

Bullying and Sexual Harassment Prevention^



Since 2014, when first asked, the percent of schools that comprehensively work to prevent bullying and sexual harassment decreased from 65% to 51%. School based actions to prevent bullying include: providing annual professional development for all school staff, publicizing and disseminating policies/rules/regulations on bullying and sexual harassment, providing a confidential mechanism for reporting student bullying and sexual harassment, and providing information and resources to parents on preventing student bullying and sexual harassment.

Specifically, the percent of schools in which staff received professional development decreased from 90% in 2014 to 86% in 2016. However, the percent of schools that publicize and disseminate policies related to bullying and sexual harassment increased from 98% to 99%.

^ *Significant difference between middle and high schools*

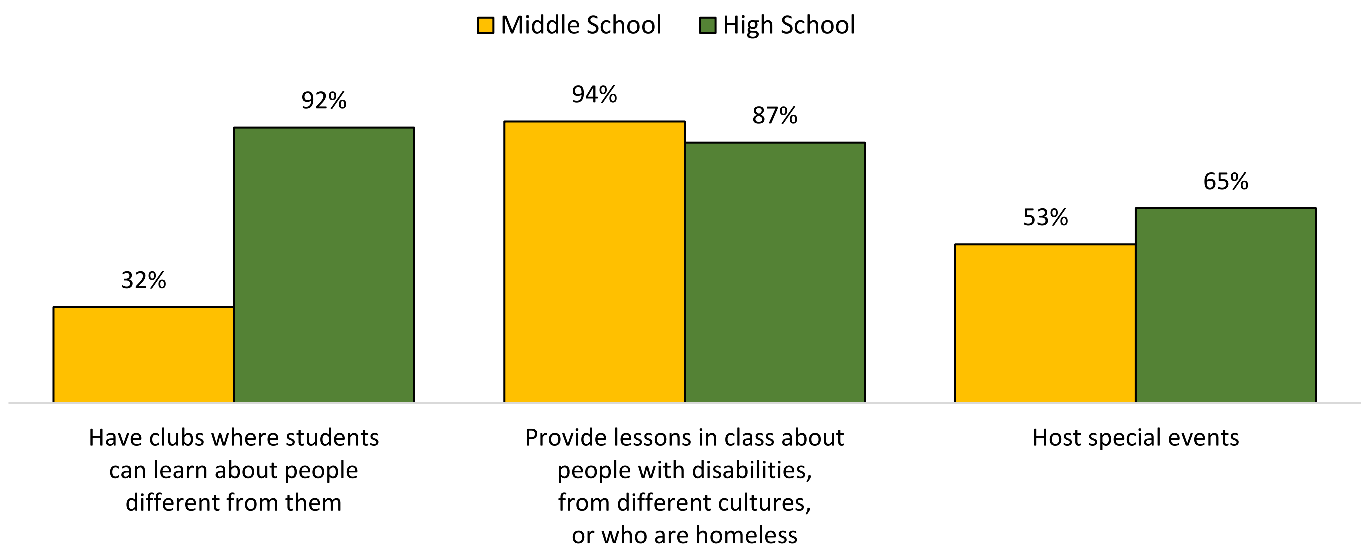
What we are doing: Creating Safe and Inclusive Environments
Bullying Prevention and Cultural Awareness
2016 Vermont School Health Profiles

Multi-Cultural Awareness

More than half of all schools have special events, student clubs, and classroom lessons for students to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures. Nearly six in ten schools have held special events such as a multicultural week or family night (58%), and more than five in ten (54%) have clubs that give students opportunities to learn about people different from them. In the classroom, most schools (93%) include lessons for students to learn about people different from themselves.

High schools are more likely than middle schools to host special events (65% vs 53%) and nearly three times as likely as middle schools to have multi-cultural focused clubs (92% vs 32%). However, high schools are significantly less likely than middle schools to include lessons about people with disabilities, homeless youth, or people from different cultures (87% vs 94%).

Opportunities to Learn about Others[#]



[#] *All differences between middle and high schools are significant*

What we know: Family Engagement and Community Connectedness

2016 Vermont School Health Profiles

Family Engagement

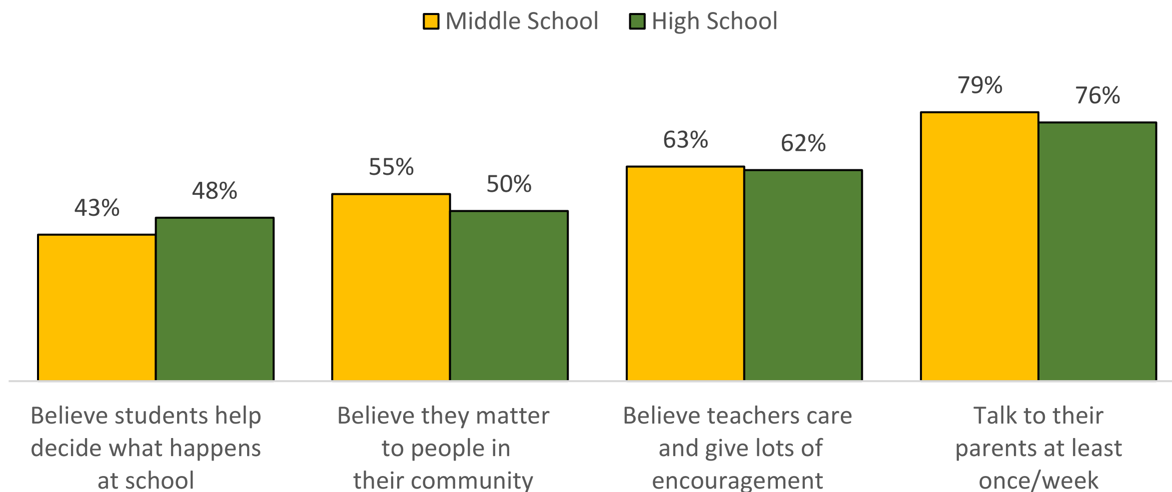
Family engagement has been linked with many student outcomes such as grades, achievement test scores, and perceptions about the importance of education as well as with positive health behaviors and less emotional distress.

Overall, four out of five middle school students (79%) and three in four high school students (76%) reported speaking to their parents about school at least once a week. Nearly half do so every day (52% and 48%, respectively). Seven percent of high school students never talk to their parents about school.

Feel Valued in the Community

School connectedness is the belief by students that adults and peers in their school care about their learning and about them as individuals.

Half of all students, in both middle and high school, agree or strongly agree that they matter to people in their community. Feeling like they matter decreases with increasing grade among middle school students. Among high school students, twelfth graders are more likely to report feeling that they matter to people in their community compared to students in other grades.



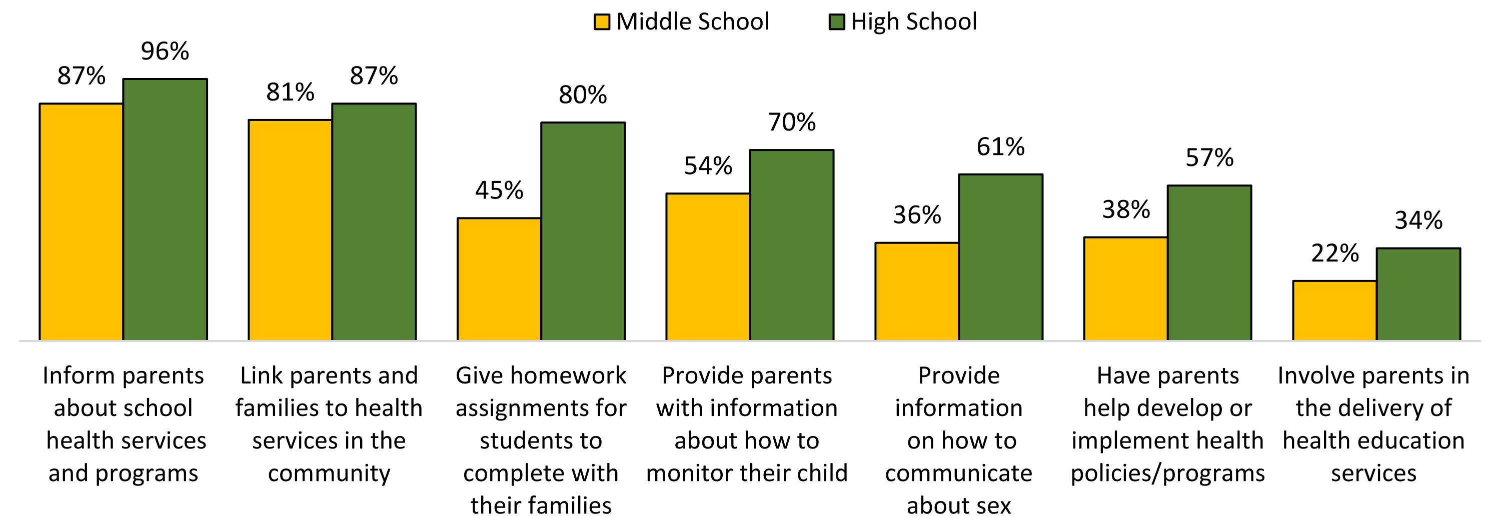
What we are doing: Family Engagement and Community Connectedness

2016 Vermont School Health Profiles

Schools can increase family engagement through a variety of strategies including: establishing one or more communication channels (e.g., electronic, paper, or oral) with parents about school health services and programs; linking parents and families to health services and programs in the community; providing parents and families with information about how to communicate with their child about expectations, monitoring behaviors, responding to broken rules, and sex; engaging parents in the development and implementation of school health policies and programs and as school volunteers; and engaging parents and students in health education activities at home.

Overall, 54% of schools engage in at least four strategies to increase parent and family engagement. High schools are significantly more likely than middle schools to implement parent engagement strategies (78% vs 45%).

Most schools (91%) use electronic, paper, or oral communication to inform parents about school health services and programs, eight in ten (83%) schools link parents and families to health services in the community. Roughly six in ten provide parents with information on how to monitor their child (e.g., setting parental expectations) and how to respond when their child breaks the rules (57%) or provide students with homework to complete with their families (58%). Four in ten schools (41%) provide parents and families with information about how to communicate to their child about sex. Less than a quarter involve parents as school volunteers in the delivery of health education activities and services (23%).



Since 2014, the percent of schools implementing at least four parent engagement strategies significantly decreased from 65% to 54%. Specifically, the percent of schools providing students with homework to complete with their family and who involve parents as school volunteers significantly decreased (70% to 58% and 33% to 23%, respectively). However, the percent of schools in which families help develop or implement policies and programs related to school health significantly increased (36% to 44%).

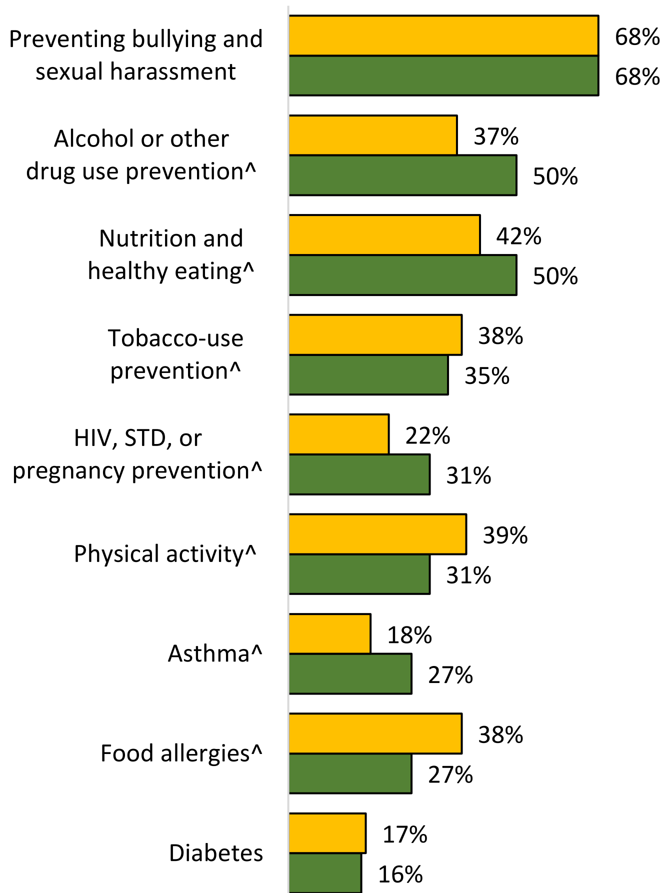
All difference between middle and high schools are significant

What we are doing: Family Engagement and Community Connectedness

2016 Vermont School Health Profiles

Health educators also provide parents and families with content specific information to increase their knowledge on various health-related topics.

Schools are most likely to provide parents with information about preventing student bullying and sexual harassment, including electronic aggression (65%). About four in ten schools provide parents information about nutrition and healthy eating (42%), alcohol or other drug use prevention (40%), and tobacco-use prevention (37%). Approximately a third of teachers provide information on physical activity (34%) and food allergies (31%). Less than a quarter provide information for parents to learn about HIV, STD, or pregnancy prevention (23%), asthma (19%), or diabetes (17%).^



As with other areas related to health, information provided to parents and families varies by the type of school. Compared to high schools, middle schools are more likely to provide information on topics such as tobacco-use prevention, physical activity, and food allergies, but are less likely to provide families with information on alcohol and drug use prevention, nutrition, sexual health, or asthma.

Since 2014, fewer schools are providing parents with information on all topics except diabetes, asthma, and HIV/STD, and pregnancy prevention.

^ *Significant difference among middle and high schools*

Policies, Programs, and Prevention

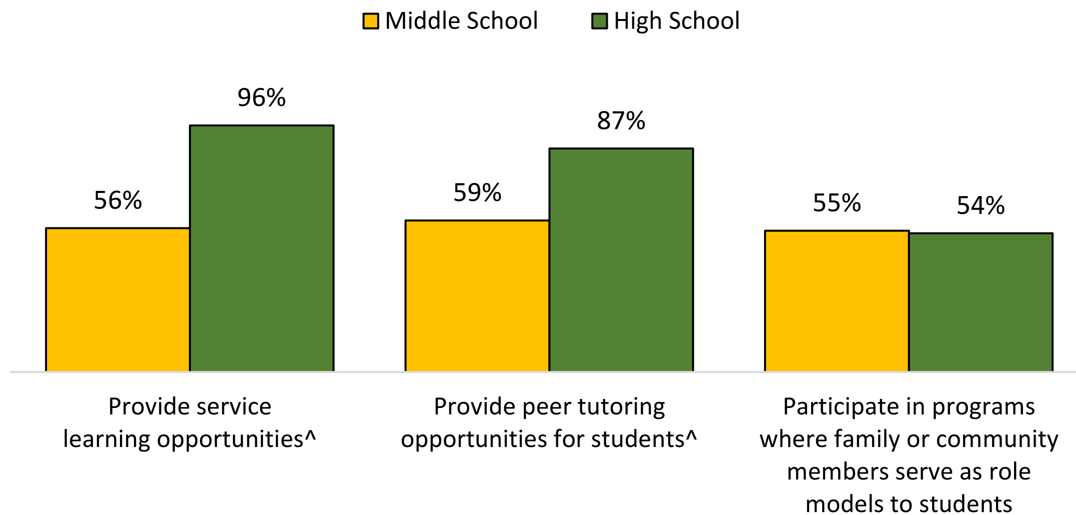
Safe and Inclusive Environments

What we are doing: Family Engagement and Community Connectedness

2016 Vermont School Health Profiles

In addition to having a lead health education teacher who received professional development on classroom management techniques and providing clubs or activities that give students opportunities to learn about people different from them, other strategies used by schools to increase school-community connectedness include providing students opportunities to peer tutor other students (72%), participate in service learning projects (70%), and having programs where family and community members serve as role models to students in programs such as Big Brother Big Sister (53%).

More than four in five (84%) schools engage in at least three school connectedness activities that are linked to safe and supportive environments. Most high schools (95%) and nearly eight in ten (77%) middle schools implement at least three school-community connectedness strategies.



The percent of schools that implement at least three school connectedness strategies significantly decreased from 86% in 2014 to 84% in 2016. There have been no significant changes in the percent of schools providing service learning opportunities, peer tutoring, or mentoring programs since 2014 when these questions were first asked.

^ *Significant difference between middle and high schools*

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