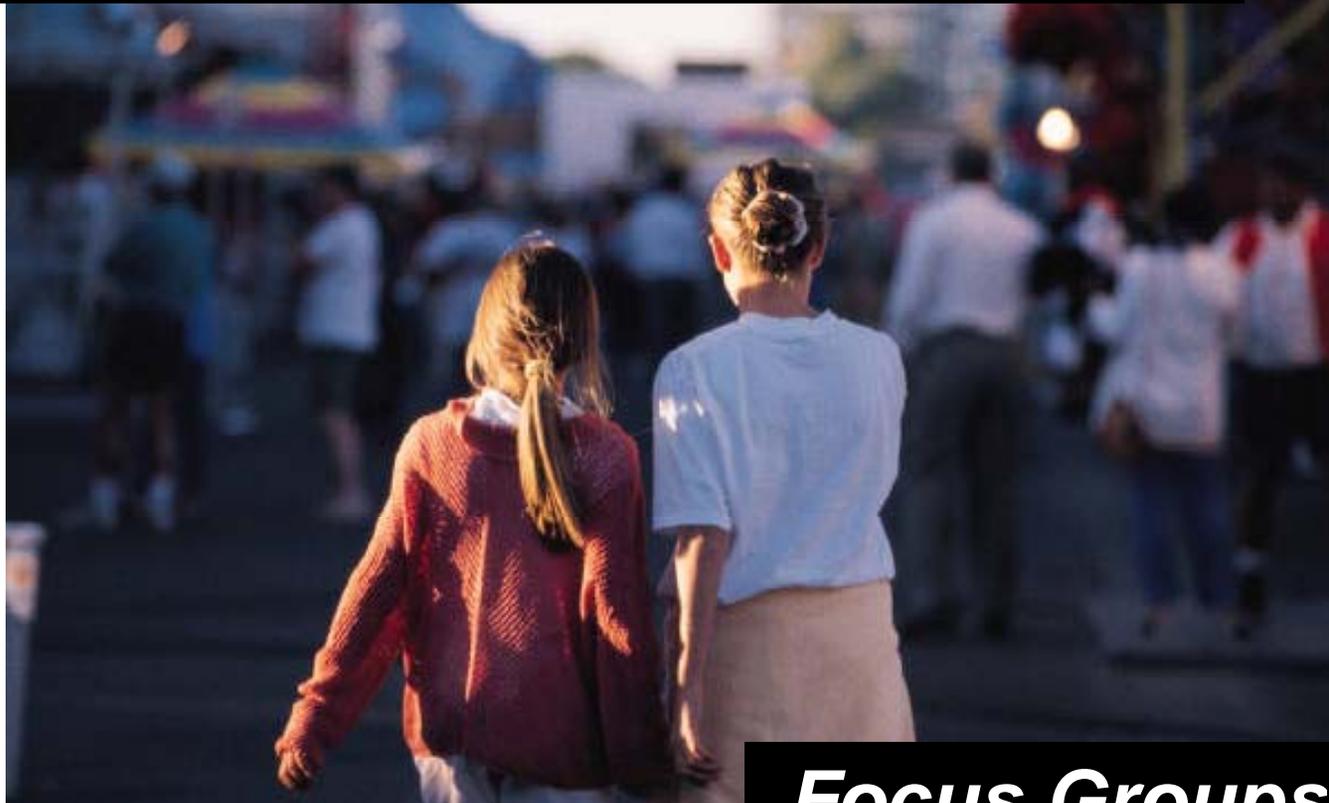


2001 Youth Risk Behavior Survey



Focus Groups

**A collaborative effort of
Boulder Valley School District &
Boulder County Health Department**

October 2002

Forward

In late 2001, Boulder County Health Department (BCHD) and the Boulder Valley School District (BVSD), in yet another successful collaboration, conducted the Youth Risk Behavior Survey with a representative sample of youth enrolled in BVSD high schools. In February of 2002, we published the results. These data gave us an honest, up-to-date look at the prevalence of high-risk behaviors and answered the question: **What are they doing?**

As Terry Bryant, our health planner, gave a series of presentations to groups interested in this information, we discovered that participants (predominately adults) had a variety of very immediate assumptions, attitudes, beliefs, and opinions about these behaviors. Many had very immediate ideas of what “we” (adults) should do to intervene and provide solutions to perceived problems associated with behaviors that were a cause for concern.

We in public health have learned that the only successful interventions are those that are developed in respectful collaboration and alliance with the target population that is directly affected by a problem. With this in mind, we contracted with a qualitative research expert to conduct a series of focus groups with youth in the school district. We knew this would provide qualitative information that would complement the quantitative data we had from the survey.

This publication is the result of that effort, and is a significant step in our process to answer the question: **What are they thinking?**

We are grateful for the willingness of the participating teens to engage in open, focused discussions about behaviors and events that are a part of their daily lives. While some of what they tell us may be cause for discomfort, it is clear that they want us to know about the complexity of their lives, and they want our help to create an environment where they may make choices that will keep them safe.

Our challenge now is to suspend judgment, actively listen, and work together to make informed decisions and adopt behaviors that protect and enhance the health of all members of our communities.



Charles L. Stout, MPH
Executive Director
Boulder County Health Department

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Introduction

During the fall of 2001, Boulder County Health Department (BCHD) and Boulder Valley School District (BVSD) partnered together to survey 1,138 high school students (9th-12th graders) in Boulder County regarding health risk behaviors that are nationally prevalent in the teenage population. The self-reported information gathered via the Center's for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) identified the following as health risk behaviors that Boulder County youth are currently engaging in:

- Unintentional injuries (accidents)
- Intentional injuries (violence)
- Tobacco use
- Alcohol use
- Drug use
- High-risk sexual behavior
- Overweight/obesity

The data were compiled in a report entitled "2001 Youth Risk Behavior Survey: the Results." This report, available via Boulder County Health Department, is being distributed and used throughout the county as a point of reference for current teenage behavior and as a tool for program planning in the community and school district.

The next stage of this study was to understand more about the context of these teen behaviors and to identify teen-

endorsed areas of potential intervention-both to prevent the uptake of high-risk activities and to address risky health behaviors already in progress. Well-intentioned adults have been involved in the program-planning and resulting interventions for teenagers for years. The point of this stage of the study was to include the teenage perspective as an important voice that would help with reality building and decision-making toward the ultimate goal of reducing death and disabilities related to these preventable behaviors.

This report summarizes the findings from a series of six focus groups with sophomore and junior high school students in six Boulder County schools. It should be noted that these focus groups, with a limited number of students, cannot represent the views of all Boulder County students. However, the triangulation of the YRBS survey data and the findings from the focus group series study provided the opportunity to examine both the breadth (quantitative) and depth (qualitative) of the combined

findings. The focus groups gave students the opportunity to reflect on the quantitative data, offer their reactions to increase understanding of the world of teenagers, and provide teen-friendly program and curriculum-planning advice.

The demographic characteristics of the six focus groups and participants are as follows in Table 1:



Table 1

Demographic Characteristics of Focus Groups (eligibility criteria)	Demographic Characteristics of Participants
Focus Group #1 At-Risk Coed	N = 4 2 males, 2 females 4 sophomores
Focus Group #2 At-Risk Male	N = 2 2 males 2 juniors
Focus Group #3 General Female	N = 2 2 females 1 sophomore, 1 senior
Focus Group #4 General Male	N = 6 6 males 6 juniors
Focus Group #5 At-Risk Female	N = 9 9 females 5 sophomores, 4 juniors
Focus Group #6 General Coed	N = 8 4 males, 4 females 2 sophomores, 6 juniors
Total 3 At-Risk Groups 3 General Groups	N = 31 14 males, 17 females At-risk N = 15 4 At-risk males, 11 At-risk females General N = 16 10 General males, 6 General females 12 sophomores, 18 juniors, 1 senior

Teen Prioritization

The format of the focus group study was to have the participants prioritize the YRBS health issues in order of perceived magnitude (“biggest health issue or behavior”) and then spend the rest of the session working with the top two or three health issues in depth. The series of six focus groups prioritized the health issues in the following order:

1. Drug Use
2. Intentional Injury/Violence
3. Alcohol Use
4. Tobacco Use
5. Sex
6. Overweight/Obesity
7. Unintentional Injury/Accidents

Findings

The findings from this series of focus groups fall naturally under the original intentions of the research—understanding the context of risky health behavior and resiliency behaviors of teens and teen-identified ways to address/reduce risky health behaviors for teenagers for each health issue. The report is organized by health issue or health behavior in descending order of teen-identified interest from the six focus groups.

Some representative quotes are included to illustrate the themes/subcategories in the teenagers' own words, as well as to provide context for the findings. Where there are differences in responses (i.e., answers specific to gender or age or subgroup), they are noted in the narrative.

Drug Use

In the Teen World

▲ Drug use is common and available, especially in the school setting.

This was a clear comment across all focus groups. There were some school and community settings where it was interpreted as more prevalent, but it was clear that drugs are available to students who want them.

Male: I know that drugs at this school . . . from what I have seen and did experience, it is definitely easier to get

than even cigarettes or anything else. Drugs—I could walk up to just about any regular person in the hallway and ask, "Do you know where I can get any weed?" And guaranteed within an hour, I could get whatever I wanted.

▲ Drug use is inevitable—a part of growing up for teenagers.

Drug use will happen—there is no denying or changing the fact that, to some degree, it exists and will always exist in Boulder (and elsewhere) for teenagers.

▲ Drug use overlaps with other risky health behaviors.

A common theme discussed in other focus groups as well was that it is hard to look at some of these behaviors without acknowledging their relationship to others.

“*Male: I keep wanting to go back to drugs tying in with, like, pretty much everything on the list—drugs, depression, all of it, in my mind, just ties together. I see it as like one big subject here.*”

▲ The school environment is not necessarily a strict-enforcement-against-drugs environment.

Students weighed the relative risk of drug use. For some, they felt that the

possibility of being caught outweighed the pleasure of drugs. They also pointed out that in the school setting, chances were you wouldn't be caught as it is a prevalent, sometimes ignored, or often un-enforced behavior.

▲ Marijuana is not seen as a harmful drug, especially in comparison to other drugs and tobacco.

There is more acceptance/tolerance for marijuana use—perhaps more in certain regions of Boulder County (e.g, Boulder City, Nederland), but it is generally accepted by teenagers. Marijuana is not seen as a gateway drug and not seen in the same addictive category as tobacco. There is a view that more people have tried pot than smoking cigarettes.

▲ Hard drugs (cocaine, heroin, etc.) are the drugs to be worried about.

A point was made that although it is happening, use of hard drugs such as cocaine is not discussed openly among students/peers at the risk of social stigmatization. Some of the teenagers noted that they are scared of hard drugs.

Yeah, well cocaine's kind of looked at as, like, this really hard, scary drug. Ecstasy's probably just as bad—well maybe not just as bad, but it's pretty close; up there with cocaine. And if you do Ecstasy, then it's okay because it's cool, but if you do cocaine, it's just kind of like people get scared, like that's not cool—because it's, like, up there with heroin, and that's not cool.

▲ **There are other examples of available drugs that are not addressed in the YRBS study.** There was a lot of discussion about other drugs not listed in the YRBS study that are prevalent, or at least available to teenagers. There are other hard drugs being used in addition to cocaine. Some of the drugs mentioned were mushrooms, Ecstasy, acid, heroin, and prescription drugs like Percocet, Vicodin, Aderol.

27% of students currently use marijuana

4% use cocaine

2002 YRBS BVSD Survey Finding

▲ **Age issues (upper-, lower-classmen) and gender issues contribute to drugs being offered/sold on campus.**

The gender issue was only mentioned in one focus group, but was agreed upon by other members of the group. Evidently, age, gender, and level of experience with drugs and sexual behavior influence drug traffic in the school setting.

▲ **There are certain times of the year when drug use is prevalent.**

When possible, times/seasons of the year were noted for potential points of intervention. Students were able to state when the “season” for “x” drug activity was

significant (i.e., summertime for acid and mushrooms, year-round access for marijuana).

Teen Solutions

▲ **Experience drug use first and make your own decision based on that experience.**

An experiential solution was mentioned in several focus groups—learn from your own experience with drugs and then integrate that experience into future decisions about drug use.

Female: I think marijuana is similar to tobacco. If you want to try it, you can try it, and the first time you try it, if you don't like it, then you're pretty much probably not going to do it again.

▲ **Make drug use safe.**

The concept of not giving up a drug behavior, but making it a safe one was brought up as a solution for teenage drug use. They recognized it not as an “answer” or way to take drugs off the map, but to acknowledge that drug use does happen, and if it does, to do it in a “safe as possible” manner.

▲ **Create teen-specific venues of activity—places to go that are of interest to teenagers and don't cater to the social groupings or cliques.**

Create or ensure that there are alcohol and drug-free events/venues that are of

interest to teenagers. Find ways to eliminate small groups/cliques of teenagers. Examples mentioned were a drug-free arcade, a drug-free rave—both of these already exist in Boulder County, but may not be well-known to teenagers.

▲ **Make education relevant and available.**

A comment heard throughout the focus group sessions, regardless of the health behavior of interest, was the idea of relevant, available education. Teenagers liked accessible, honest, straight-up, candid, open communication that explained all aspects of drug use.

Male: What they do to you socially, mentally, physically; the effects that drugs have and why drugs are bad. I mean maybe more explanation on why there are laws against drugs, stuff like that.

▲ **Allow more time for health education in the schools.**

Although the comments often referenced school-based issues, this can be extrapolated to community settings as well. Teenagers felt that they didn't have enough time devoted to health issues that are very relevant to their lives, including drugs.

Female: Health class is only offered one semester throughout your entire career of high school. I think that's just ridiculous, considering what all the high school kids are going through and what kind of issues we're dealing with. Like one semester isn't

going to cover anything, let alone, like, one semester start your four years; and it's only offered to juniors and seniors.

▲ **Create messages/media messages that remind teenagers about how they are influential in other people's lives.**

Address teenagers for their role in influencing others in their lives, particularly younger brothers and sisters.

Female: I'm thinking about a pretty good ad that's about marijuana, but where it's, like, the older brother or sister, and they won't do it because the little boy is right there and looking at them. And that's true, because if I had a little brother or sister, there's no way they would ever see me doing anything bad like that, because you do, like, you're an object of, like, your older brothers and sisters, and you're going to try and be like them.

▲ **Ensure that the drug educator is a credible, honest messenger.**

For some students, a credible, honest messenger was someone who had been through/experienced "x" health issue. For others, it was someone who they could completely open up to and talk to about anything. This messenger was described as a family member, a friend, or a professional. Regardless, the person was a credible, honest messenger who made a difference and/or influenced a health behavior decision.

Male: . . . if you're going to have someone that's going to try to teach you on drugs, I

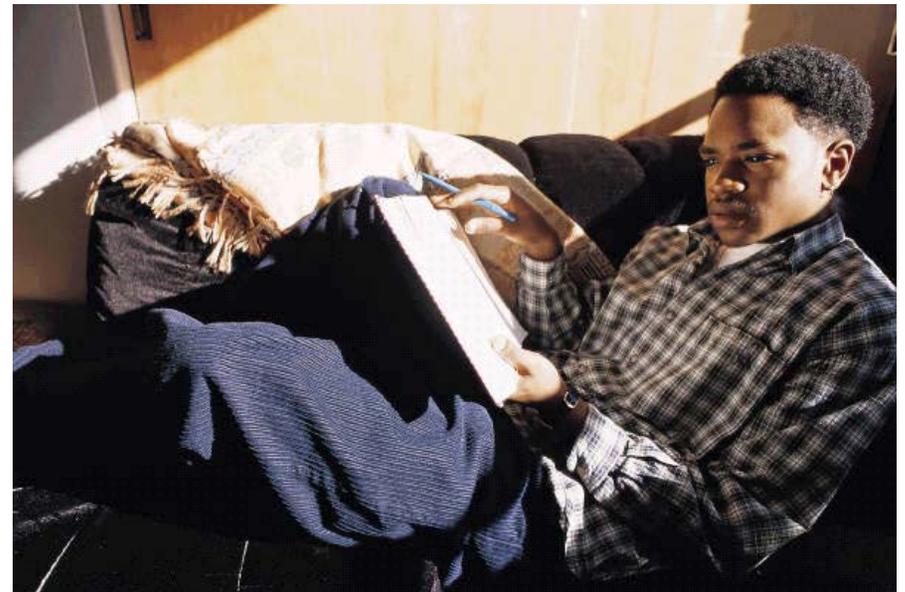
would say that it'd be more, like, effective on at least someone like me if I saw someone who had actually . . . who's already actually been around it or done it and told you what the effects of it were, and what it does to you, and how it can affect you later . . .

▲ **Enforce drug policies.**

Teenagers seem to be fine about the possibility of more enforcement of drug policies on campus (e.g. more security cameras, random drug checks, drug-smelling dogs). Even though it would be giving away a bit of freedom, the possibility of lowering drug use, especially hard drug use, on campus was freely discussed and endorsed by focus group participants.

▲ **Punishment with consequences.**

Along with enforcement, students felt that school policies regarding punishment for drug-using behavior was sometimes lax, inconsistent, or not applicable to the "crime." They said that it was important to punish drug users with consequences that would make a difference.



Intentional Injury/Violence

In the Teen World

▲ **There is competition and stress in school/community, creating violence.** Stress and competition were brought up as social issues that teenagers deal with, especially in the school setting, but also in the community.

There's a lot of competition between teenagers. You know everything's about . . . being cool and then when there's that much conflict, everybody eventually gets mad and . . . gets in fights then . . . to get ahead and eventually . . . that can turn violent instead of just being competition for like a better car or whatever, you know.

▲ **Physical violence in the form of fights is inevitable.**

Recognized by most of the focus groups as inevitable, the concept of physical violence was seen as a common occurrence amongst teenagers.

Male: I think fights are going to happen pretty much no matter what you do.

Male: Yeah, it's like a high school thing, you know, like, it's been going on for, like, years, since high school was started, and it's just teenagers compete and I don't really think there's any way to

During the past year...

19% of females & 35% of males were in a fight

2002 YRBS BVSD Survey Finding

stop that.

▲ **Definition of fight includes a range of physical/emotional intensity.**

The definition of "physical fight" was brought up in two different focus groups. Physical fights were described in the sense of teenagers being the victims of violence. Bullying, threatening, posturing were all risky behaviors identified and affirmed by others. Emphasis was on the victim- and a way to address this was with confrontation (by someone else, bigger more threatening). At the same time physical fights were acknowledged as ways to release stress/aggression for males. The participants indicated that the definition of a physical fight could be interpreted differently by different people.

During the past year...

25% of students felt sad or hopeless for two or more weeks in a row

15% of students were considering attempting suicide

6% of students had made a suicide attempt

2002 YRBS BVSD Survey Finding

Male: When people say they've been in a fight, it's not necessarily like they want to be. For example, sometimes they'll just, like, punch someone in the stomach, and they consider that a fight or something. It's not always a fight.

▲ **Physical fights are not uncommon and attributed to adolescence, hormones, normal for teenagers.**

Like drugs and alcohol (but not as widespread), the concept that physical fights were common and a normal part of teenage life was expressed in different focus group sessions.

Female: You see it a lot. I think mostly in teenagers, because there's, like, huge hormone imbalances that cause us to, like . . . I don't know exactly how to say it, but we tend to . . . our emotions are very high-strung, and so we act on what we feel all the time. We're more highly strung and feel really strongly about stuff. We haven't learned to pick our fights yet, or certain people haven't learned to pick their fights yet, so certain people, like, little stuff . . . like you took my sunglasses. That could lead to a fist fight because people are so high-strung.

▲ **Sad and hopeless feelings are not uncommon, and are attributed to adolescence, hormones, normal for teenagers.**

Dealing with the stresses of teenage life includes mental health issues in the form of feeling sad and hopeless at times. This was brought up in several focus groups as



a common occurrence and not unusual to experience.

Female: Yeah, you're, like, changing, and I know . . . sometimes I don't even know, especially, like, even a year ago, I was an emotional freak. Not even on purpose, but sometimes I could be watching the Hallmark commercial, and I'd cry and, like, that's just how it was; like my emotions were everywhere. And not only just, like, natural stuff, but I definitely think other kids have a big effect on it, like, on other kids' emotions too. And high schools aren't particularly a friendly place to be either if you're not . . . if you don't have friends.

▲ **Distinction between sad and hopeless and depression.**

Some teenagers voiced a distinction between the natural teenage expression or experience of being sad and/or feeling

hopeless and the mental health condition of depression. Depression is also considered a common occurrence amongst teenagers. Different teenagers referenced friends/peers who had attempted suicide recently.

Female: Well, because everybody in their lifetime is going to feel sad and hopeless—there's no way you can stop that. Now whether or not that happens during high school or your teenage years, that's hard to say. It probably does, but I think there's a difference between feeling sad and hopeless and actually going through a depression.

▲ **Sexual force/rape is difficult to talk about and difficult to document, due to the shame and guilt aspect.**

The YRBS statistic about “at sometime in their life . . . 5% of students have been forced to have sexual intercourse” was a statistic that was not addressed voluntarily by teenagers. Of all the statistics offered, that was one that was the most difficult for teenagers to react to and give contextual remarks. One person referenced the shame and guilt aspects in connection with the act of forced intercourse as being a reason it might be un- or under-reported.

▲ **Definition of forced sexual intercourse under-reports reality.**

One person stated that sexual intercourse is one of many forced sexual activities that teenagers are aware of and might participate in. The definition of sexual intercourse therefore limits the possibility of understanding the breadth of non-voluntary sexual activity among teenagers.

Female: . . . I don't think that [it should be] just sexual intercourse; I think it should be broadened. I mean things sexual, because people are forced to do sexual favors all the time, and it would definitely be higher if it wasn't just sex. Because it can be anything having to do with anything sexual.

Teen Solutions

▲ Increase security measures to address opportunities for violence.

More security on campus (and in the community) is acceptable to teenagers as a way of preventing or lessening the potential for intentional injuries.

“*Male: It’s not, like, I mean . . . pretty much like I would consider that rape, and I mean there is some education at school about that, and, like, who girls can talk to, and even guys too—who you can talk to, there’s a little bit about education, but there’s not nearly enough.*”

▲ Expose people to other perspectives—get rid of the group/clique effect.

The effect of peer pressure in the form of groups was evident in several of the focus group sessions. Some of the teenagers in one focus group in particular had experienced a program called “Breaking Down the Walls” as a way to “break down” the walls of people who only hang out with their friends and not benefit from new perspectives. The focus group session

was referenced as an experience in doing that—creating a setting where “strangers” can get together and share their opinions on things that matter, like health behaviors. These examples were seen as positive, structured “interventions.”

▲ Increase violence education opportunities.

A need was identified to increase education in the way of violence prevention. There was an acknowledgement that such education exists, but that there is not enough of it.

▲ Community intervention in the form of education for parents.

The concept of an “askable,” open-to-communication parent was common amongst focus group participants. Teenagers thought that it would be good to offer educational opportunities to enhance parental abilities to identify health risky behavior and act on it through good communication.

▲ Find/establish good social support/mentorship possibilities.

Parents are one of the many potential resources for open communication and opportunities for education about violence and other health risk behaviors. Social support in the simplest sense of the word—someone to talk to—was raised in many of the focus group sessions.

Male: And going back to what I was saying before, is that would definitely just open up more people for teenagers to talk

to. Just maybe if their parents understood their lives a little bit better, and people in the community understood their lives a little bit better, that then they could maybe open up a little more.

Alcohol Use

In the Teen World

▲ Alcohol use is okay/acceptable among teenagers as long as you are responsible about it.

There were a lot of similarities with alcohol and drug use, especially when comparing alcohol to marijuana. These two drugs are seen by teenagers as less harmful than other drugs, especially when treated in a “safe” manner. Although many viewpoints were shared, the discussions around alcohol and marijuana tended to be more about harm reduction than prevention.

▲ Younger people are more susceptible to “not being safe” about drinking.

Age came up as a reason why teenagers may not behave in a safe way about drinking. It was described as a common phenomenon, a rite of passage, to be young and starting to drink.

Female: the younger (students are) . . . the ones that are, like, ohhhh, older classmen . . . like yeah, you know, like, we're going to go out with them; we don't know our limits, we don't know what we're doing. They're the ones that I think are, like—no offense if anybody's an underclassman—like, more easily swayed to do, like to drink or not drink and do all that, and they're the ones that would

probably be, like . . . because I know I was like that, I was invincible when I was little, and I'd go out and drink and drive . . .

47% of students currently drink alcohol

In the past month . . .

32% of students have been drunk

10% of students drove after drinking alcohol

2002 YRBS BVSD Survey Finding

▲ Alcohol is common and available to teenagers.

Alcohol, like drugs in school and in the community, is available, despite the age restrictions for purchase.

Female: Like, there may be other easier drugs to get a hold of . . . but alcohol is not hard to get a hold of at all.

▲ Teenagers know there is a difference between alcohol use and abuse.

Teenagers are aware of the consequences of alcohol and consider themselves to be knowledgeable about the difference between alcohol use and abuse.

▲ To drink or not to drink is an individual decision.

There was a viewpoint shared that there is pressure to use alcohol and drugs, but it is not fair to blame your use of these ON the pressure—it is an individual decision.

▲ Forbidden fruit—it is fun to do what you are not supposed to do.

There is an element of risk taking and adventure to do something that is not legal or not condoned by adults.

Male: . . . half of getting drunk is the fun of getting the alcohol when you're not supposed to, and having possession of that, knowing that just kind of walking that danger line, kind of knowing that you can get in trouble for it, and so when you have that opportunity, getting as drunk as possible. It's just a case of forbidden fruit tastes the sweetest.

▲ Teen social gatherings/peer pressure promote drinking.

Teen social gatherings were described as places where it might be difficult to be able to say “no” to drinking.

Male: I do think though that, like, if you're at a party and a lot of people are drunk or just drinking, I think that it does depend on the individual more. I think everything depends on the individual, but I think there are a lot of individuals who would say, well they're drinking, and I don't want to be the only one who doesn't drink and have everyone ask me if I want

a drink and every time saying “no,” then they start drinking a little bit or they may enjoy getting drunk quite often and so they start drinking to get drunk. So I think there’s some temptation there.

▲ **The range of teen drinking behavior is from drinking socially to drinking to get drunk, the latter being more common.**

Teens represented that there was a range of drinking behavior, but the comment that the combination of teenagers and alcohol usually meant that they are trying to get drunk was more common than abstinence from drinking.

▲ **Alcohol does not taste good/is not attractive to some teenagers—this is not necessarily a deterrent for alcohol use.**

This comment was stated in two different focus groups—both making the point that teenagers drink something that doesn’t appeal to them in order to have the benefits of drinking alcohol—e.g., social pleasure, social acceptance, being drunk.

▲ **It is difficult to see the long-term effects of alcohol and integrate this knowledge into current decision-making.**

The point was made that alcohol, unlike other substances with direct effects (e.g., tobacco use has probable links to cancer), is difficult to show how it has a negative influence on your life in the long term.

Male: . . . I mean, if you get drunk a week before you have a big athletic event, it’s probably not going to affect your performance in a week.

Teen Solutions

▲ **Be aware of what doesn’t work.**

Teens were able to identify what hasn’t worked for them in the past as a way to identify what might be useful for future interventions/program planning. They listed the following as “not working” to reduce their use or attitudes about drinking:

- Don’t scare us with pictures of mangled cars.
- Don’t just tell us not to drink.
- Don’t tell us that teenagers are bad if we do drink.

▲ **Institute/educate people about harm reduction—focus on allowing drinking behavior in a “safe” way.**

Set up a situation where alcohol is “safe” and teens are “responsible” about it.

Female: When I was little, my mom would (say) . . . if you want to drink, you need to be here, you need to have a designated driver. I think they just need to teach that stuff more, like, this is how you’re going to be a safe drinker instead

of . . . just drinking’s bad and you’re going to end up bad if you drink . . .

▲ **Include some “reality education” that shows the effects of alcohol.**

Along with the concept of experiential learning is reality-based learning—taking the “dreamy side” of alcohol away.

Male: Yeah, just try and mix in as much reality to something that’s possible, because just like with marijuana, I mean, it’s the dreamy side that everybody likes, and, like, the true side is always a little bit of a letdown.



▲ **Increase/maintain cost of alcohol.**

For some teenagers, the cost of alcohol is a barrier to consumption, or major consumption (of alcohol).

Male: With me personally, it’s not a worthy expense of money, because sure, I can get alcohol here on campus whenever I want to, probably any day of the week, but I’d have to go pay \$30

for a bottle of vodka or something.

Fac.: So money is a deterrent?

Male: For me, because I have much more interesting things to spend money on, and so do all my friends.

▲ **Help teens get busy/be busy with activities/create teen-specific venues of activity.**

Teenagers who have something to do don't think about the alternatives, which could include risky health behavior(s). Address teen boredom; intervene during specific times of day when teens are not active; address the social gaps that limit where people under the age of 18 can go.

Male: . . . having something to do, because when you're bored, you're going to drink. I mean it's boredom that leads to a lot of these things—to drug abuse, alcohol abuse, tobacco.

▲ **Make education more reality-based—include real stories from real people about the effects of alcohol.**

Having a credible messenger with factual stories about the impact of alcohol is effective.

▲ **Include harm reduction in educational efforts.**

Teach people who can help others to be safe about their drinking and behaviors related to their drinking. Incorporate the concept of harm reduction into other educational messages about drinking.

▲ **Educate parents about teenage drinking and what their role can be.**

Educate parents so that they are aware of the issue of teenage drinking, and so that they can play a role in teaching teenagers not to drink or not to drink in an unsafe way. Parents need to be open to

communication with their teenage children.

▲ **Peer education about the acceptability of not drinking.**

Find a way that peers can spread the message that not drinking is alright. It needs to come from people about the same age and it needs to be genuine.

Female: The way people respond to them when they tell them they've been drunk, because I used to drink a lot until I . . . like this year, I just switched schools, and I found a bunch of new friends, and the friends I found here, they don't support that . . . they don't think you're cool or whatever for getting drunk. Whereas the ones I had at my old school did, and that has changed it a lot. I think a lot of the way you could stop that is by changing people's reactions to it, like how they respond to it.

▲ **Group interventions, such as “Breaking Down the Walls.”**

“Breaking Down the Walls,” a group intervention in the school setting, was brought up in reference to intentional injury and alcohol. The intervention addresses the peer effect at the group level and was seen by focus group participants as helpful. One of the aspects of this program is to expose teenagers to other teenage perspectives—get rid of the peer or clique effect. In the case of alcohol, it was seen as a way to show that not drinking was an okay behavior for teenagers.

“*Male: And it talks about it's okay not to drink, and I think in order to do that, you sort of have to get more than half the people not to drink, because if you're sort of in the small majority that's not drinking, you sort of feel like you're missing out on what the bigger group is doing, and so you sort of want to be part of that bigger group.*”

▲ **Teach teenagers to address the environmental issues of drinking.**

Teenagers can benefit from friends/an environment where there is not peer pressure to drink—who you hang out with matters. This point was brought up in regard to several health behaviors. Peer pressure is a strong influence for drinking. If you put yourself in a situation where the peer pressure is not there, then you have a better chance of not taking up the behavior, or abusing alcohol.

Male: I mean it's the people who really want to be accepted that are much more susceptible to any form of behavior problems like these that you have on your list; not just drugs or alcohol, but anything.

▲ **Experiential learning.**

Create a situation where you learn by experiencing—either the true effects of over-drinking or simulated negative effects of drinking so that you can learn how that can affect your life and choices.

Female: Kids in school learn better by experience. Maybe if you had a simulator, not like you'd give them alcohol, but if there was, like, a simulation of it maybe they would not . . . like at the history museum, like, this is what you're like when you drive drunk, and then you always crash.

▲ **Address alcohol and you will address some of the other health behaviors as well.**

The overlap or influence of alcohol on other health behaviors or health issues was discussed in several focus group sessions. Students made the point that making the situation of drinking alcohol “safe” could also lessen some of these other risky health behaviors.

Tobacco Use

In the Teen World

▲ Tobacco is easily accessible to teenagers.

Even though there is an age limit of 18, it is possible and easy for teenagers to acquire tobacco products.

“Female: . . . it’s so easy to get cigarettes or chew or whatever; it’s so easy.”

▲ Smoking is bad/wrong/unacceptable to many teenagers and influenced by peer pressure.

The power of other people your age recognizing publicly that smoking is not acceptable behavior has and can influence the reduction of tobacco use.

▲ Teenagers know everything there is to know about tobacco.

Students feel very strongly that they have learned everything about smoking via other classes and early messages in life. They are clear about tobacco—who quits tobacco and why and when.

Female: I think that it’s really hard because I think that we are really informed about tobacco, I don’t think we could be more informed. We’ve been learning about it since we were in elementary school, and I think there’s nothing else

they can do. If people are going to do it, they’re going to do it.

▲ The prevalence of tobacco/smoking friends can influence smoking behavior.

The pressure to smoke is greater when it is within your environment “in your face.”

▲ Social gatherings (e.g., parties) and who gathers socially can influence tobacco use, even temporary tobacco use.

Both the party influence and the people who attend the party can influence the use of tobacco in a social gathering.

Female: But I don’t think it’s really preventing kids from, like . . . because it’s just who you hang out with. Like you said, like, none of your friends smoke. But I go to parties and people that, like, don’t smoke on a regular basis are just chain smokers and just downing cigarettes and just, like, going through packs just because it’s, like, what you do when you’re bored at a party or something.

▲ Depression/stress can influence tobacco use.

People who are depressed or dealing with stress in their lives seem to smoke more than the happy, less stressed, more “resilient” people.

Female: Yeah, it seems like people who are actually, like, kind of down and stuff—you can tell that they’re down. I’ll also be walking by “cancer hill” and I might see

that same person out there. Whereas the one who’s always totally happy, totally like, “hello everyone,” you know, I probably wouldn’t see them out there.

▲ Tobacco does not have an “immediate effect” – thus influencing teen decisions about smoking.

Although students may have knowledge about tobacco outcomes (e.g., cancer, death), these effects are not readily/immediately apparent. The sense of living in the present and invincibility contribute to the rationale that smoking is okay right now.

Male: The really bad thing about tobacco is that, like, there’s no immediate effect on you, like, immediate negative effects. Like drugs, you know you see a lot of kids do too much drugs and they’re kind of wandering and whatever, and alcohol you can’t . . . alcohol poison and everything, but tobacco, you know, it takes a while for something really bad to happen.

▲ There are strong messages about not smoking in the schools/community, but there are double standards regarding the messages.

Students are aware of the school policies/community policies regarding tobacco use, but still witness tobacco use in practice.

Male: But still, it’s supposed to be a non-smoking school.

Female: It should be non-smoking, but we pretty much have a designated area to smoke.

Female: Yeah, I mean there's janitors and people like adults, that go out and smoke with the people that are smoking outside.

▲ **Teens are savvy to the role that tobacco companies play in influencing them to smoke.**

Teenagers know the power of the tobacco companies, and how their wealth and power plays a significant role in the larger picture about tobacco and smoking behaviors.

▲ **“Other” tobacco products (e.g., chew) are appealing to students who have (external or internal) rules about smoking.**

Some teenagers see chew as an alternative to tobacco to avoid smoking rules, or because the perception is that it doesn't hurt your body enough to prevent you from doing things you like to do, such as being active or participating in sports.

▲ **Parents/other adult figures play a role in influencing teen smoking behavior.**

Adults have been smoking for generations—teenagers witness this behavior and are interested in trying to smoke.

Male: Because it doesn't help that off-campus is just across the sidewalk and that's also off-campus for the staff

members, so you have teenagers smoking with the adults. And I don't know if the adults smoking actually affects the teenagers, but there are adults smoking with you, so it doesn't seem that bad.

Teen Solutions

▲ **Be aware of what doesn't work with tobacco messages.**

Focus group participants were clear about messages that didn't work with regard to tobacco. They listed the following as “not working” to reduce their use or attitudes about smoking:

- Don't try to scare us.
- Don't tell us blanket statements without explaining the reasons behind it.
- Don't just tell us that it is bad or wrong to smoke.

▲ **Improve media messages related to tobacco.**

Focus group participants had different opinions on what might work in terms of the media and messages about tobacco (e.g., using more graphics, showing reality, being very visual, very factual). Include real people showing the effects of smoking behavior.

▲ **Enforce school/community policies about tobacco; punishments should be reasonable.**

There are currently school policies about tobacco in place. Be sure that the message is clear and that there are punishments involved when breaking the

policies. Punishments should be appropriate to the level of the policy infringement.

▲ **Address the underlying environmental causes of stress.**

Find ways to identify and address the factors that cause teenage stress with the thought that stress leads to the uptake of risky behaviors like smoking.

Female: I think it's now since we know everything, like, we know all of the reasons why not to, I think we need to . . . I think society needs to give us a break because I see that stressed-out people, and like, bummed-out people, that's why they smoke. There's too much stress, you need to shorten our school days; you know, give us a break.

50% of students have smoked cigarettes at some time during their life

29% of students currently use some form of tobacco

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Sexual Behavior

In the Teen World

▲ **Sexual intercourse/sexual behaviors among teenagers is common and accepted AS WELL AS the decision to not have sex.**

Both sexual behavior (including intercourse) and abstinence are acceptable in the teenager world. Perhaps not equally acceptable behaviors, but both are regarded as okay by teenagers.

Female: In my mother's generation, girls who wore makeup and black eyeliner meant that they were the tramps—the girls who had sex, and that was bad. Now my mom looks at me when I wear makeup, and I say, "Mom, just because I am wearing makeup you think that I am having sex?" It is different now. It doesn't matter whether you are a virgin. This applies to both boys and girls. And yes—it is okay nowadays – truly accepted – for teenagers not to have sex. Sex or no sex is equally accepted.

▲ **Sexual activity is inevitable—a part of growing up for teenagers.**

Sexual behavior is common in the teenage world—this was clear via the focus groups and comments that showed that it was normal behavior in their world.

▲ **Sex is common because it is “adult-like” behavior.**

Teenagers like to live in the adult world, and sex is acceptable, adult-like behavior.

“*Male: Well, yeah, you can't stop teenagers from trying to have sex, from experimenting; you're a teenager, that's what teenagers do.*”

▲ **Sex is common because teenagers think they are invincible.**

Teenagers think that they are young and able to make their own decisions, and that nothing bad will happen to them.

Female: The stereotype—and I hate this stereotype, but I am finding that it is true—is that teenagers think that they are invincible. Well—that is true—we do. You do all these things and then later, when it is too late, you have an epiphany—ahhh! My parents, teachers, whoever told us this, they were right!

▲ **Sex is common because it is very evident in the media and society.**

Teenagers made the point that sex is everywhere they look—in the media and in societal norms.

Female: The media has made it more prominent. Sex is everywhere. We've

been raised around it. It is our norm. Think about it—any conversation that any of us has right now, and how quickly the conversation turns to sex.

▲ **Sex is common because teenagers are bored with nothing else to do.**

Teenagers who are not busy with structured activities, or otherwise occupied, may find themselves experimenting in risky health behaviors, including risky sexual behavior.

Male: It's “x town in Boulder County,” what else is there to do, right?

Fac.: So it's this area, are you saying that people have time on their hands?

Male: Yeah, you get bored.

Fac.: And when you're bored, this is one of the behaviors you might do?

Male: That and drinking and partying.

▲ **Teenage sex may not be as common as everyone thinks due to the social norming process amongst teenagers.**

Teenagers may not represent accurately, the world that they are living in with regards to the prevalence of sexual behavior.

Male: The data are kind of off.

Female: People assume the numbers are higher, but probably aren't.

Female: If you were to take a random person and ask them, they would tell you that this is happening more than what is actually happening. Everybody thinks everybody is having sex.

▲ **There are some gender-based stereotypes for teenagers who engage in sex.**

There was agreement in two different focus groups that there were different stereotypes that exist for males and females—traditional stereotypes that it is okay for guys, but not for girls.

Female: I have a big issue with this topic. Everybody does it, BUT when girls do it, they are called a “tramp”; when guys do it, they are called a “stud.”

18% of students are currently sexually active

37% of students who are sexually active did not use a condom the last time they had sexual intercourse

32% of students who are sexually active used drugs or alcohol the last time they had sexual intercourse

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▲ **Risky sexual behavior can overlap with other risky health behaviors.**

Some teenagers brought up the issue of sexual behavior with other behaviors discussed in the YRBS survey. Drugs and alcohol can contribute to the occurrence of risky sexual behavior.

Male: I said this (sex) was number one because it relates to everything else, and like, my experience with it was especially like the drugs and alcohol part, because I know that when I was high, like, I had sex a lot more. And then after sobriety, I did one time, like, monogamously with my girlfriend that I had been going out with her for a year.

▲ **Prevention discussions (i.e. sexually transmitted diseases, use of condoms) do not happen between partners, and therefore, risky sexual behavior occurs.**

Teenagers talked about how difficult it was to talk about prevention before it was too late for proper prevention measures to happen.

Female: People don't ask about STD's before having sex . . . I mean that sex is overlooked—it is not part of the conversation. You are following your hormones and in the situation. When you are in the moment and having sex, that's when the mistakes are made, like not using a condom, or talking about STD's. Female: something about passion . . . Male: (agreed). Yeah, people don't talk at that time.

▲ **Social gatherings (e.g., parties) can influence high-risk sexual behavior.**

Examples of risky sexual behavior happened while attending social gatherings like parties, with alcohol and/or other drugs involved.

▲ **Parents aren't easy to talk with regarding sexual matters.**

There was a lot of discussion about the fact that parents, sexual beings themselves who also had sexual experiences when they were young, have a hard time discussing these issues in a way that is comfortable with teenagers.

▲ **Forbidden fruit—it is fun to do what you are not supposed to do.**

As noticed with some of the other health topic discussions, there is an element of risk taking and adventure to do something that is not condoned by adults (e.g., sex).

▲ **Condom availability varies for different teenagers.**

Some teenagers felt that condoms were easy to get; others found them hard to purchase, or get in general.

▲ **Condoms can be uncomfortable.**

Some teenagers felt that condoms were not comfortable to wear.

Teen Solutions

▲ **Talk about the “other” outcomes of sex, not just the parts that are positive.**

Teenagers stated that sex is prevalent in their world, but that it is rare to see the “bad” outcomes of sexual activity. These messages need to be incorporated into the overall messages about sexual activity.

Male: I think that one thing that can be changed is to have the media or education talk more about the outcomes of sex. Not just that it is great—which we see all the time and know—but what can actually happen. You know then that you are not a kid any more. Sex can change things dramatically. Our society has accepted the positive things about sex. We don't see enough about what the bad outcomes of sex are.

▲ **Include abstinence in the repertoire of options for prevention of risky sexual activity.**

Teenagers liked the idea of abstinence—not as the only option, but as one of the options to prevent risky sexual activity.

▲ **Consider the “right messenger” regarding risky sexual behavior messages to teenagers.**

Teenagers discussed the appropriate “messenger” for the topic of risky sexual behavior prevention. The main message was that it should be a person who could talk about reality and relate it to their world. This usually meant that the person was close to their age and had experienced that reality.

▲ **Consider the “right message” regarding risky sexual behavior.**

Teenagers also had some tips on what should be included in strategies for health education and/or in the media. Include reality-based examples in health education so that students become familiar with different outcomes of risky

sexual activity. Don't lecture. Don't tell people what to do or what not to do. Be clear and address all issues. They also stated that they want to be sure that they can get the right information about sex when they need it. Sometimes they go to sources that don't feel reliable.

▲ **Open communication is best.**

Whether talking about their parents or regarding messages in the community and schools regarding sex, teenagers made it clear, as with other health topic areas, that open, straightforward communication was appreciated.

Female: Also just making everything more open. Like, if you look at the European countries like France and Germany and England, they're really open about that and their pregnancy rates are lower, their STD rates are lower.

Fac.: Describe what “open” is. How can we make it happen?

Female: It's not taboo.

Female: Not taboo about talking.

▲ **Make contraception, especially condoms, available/accessible/affordable to teenagers.**

Find ways to ensure that contraception, especially condoms, can become more available to teenagers. In the general male focus group especially, males gave ideas about how to make this happen.

▲ **Make testing for HIV/STDs more available/accessible/affordable to teenagers.**

Find ways to ensure that teenagers have access to and feel comfortable about being tested for sexually transmitted diseases. Look at issues like accessibility/cost of contraception, distance to travel, how to get teenagers' attention regarding where to get information/testing services.



Overweight/Obesity

In the Teen World

▲ **Obesity/overweight issues are prevalent in the world of teenagers.** Even though fewer groups chose this topic as the “# 1” health issue, there were references to weight and perception of weight in other discussions. Body image and behaviors related to weight and weight control are big issues for teenagers.

I chose overweight and obesity as number one and it's kind of obvious why, because myself included, I know probably two-thirds of people I know are dramatically overweight. I mean not like hyper-obesity or anything, but you know 20-30 pounds, and that can lead to massive system degradation and all sorts of health risks. So I chose that as number one because it's the one I'm most confronted with every day.

▲ **The media is powerful in influencing teen beliefs in “what is fat” and how their bodies are perceived in society.** The media portrays a body image that is difficult to reach or maintain for teenagers, yet it is the “standard.”

Male: Personally for me, I know that I'm not fat and I used to think that I was, and that's what everybody had convinced me. I mean, well, not everybody, I mean

media-wise, I was convinced that I wasn't extremely buff and toned, and if you couldn't see every muscle in my body, that I was fat. And I think that that's in general, especially in this community, where pretty much most of the teenagers wear GAP and Abercrombie, and those companies specifically say if you don't look like this, then you're fat or you're not going to be accepted.

▲ **The media, industry, society, and peers all play a part in influencing perception about body size.** Several factors have influenced the trends that are played out in society where teenagers have a perception about body size and act upon that perception.

Male: I used to be overweight, and actually, I'll tell you exactly the story of what happened with me is, for a while, I starved myself and this was like a couple years ago. I starved myself just so I could fit into the clothes that everybody else was wearing that looked good.

Fac.: And what was the cause of that?

Male: Social acceptance completely. What you wear determines where you are socially.

▲ **There is a gender difference in perception of weight and a “standard” that is acceptable in society.** This was discussed more in a coed focus group than the all-male focus group, but it was touched upon in both—there are gender differences in both perception and expectations about body size.

Female: Guys are more accepting of other guys. Girls are more accepting of the overweight guys. Whereas, like, if a chubby girl walks in the school, she's going to get made fun of. There's no

8% of females & 15% of males are either overweight or at risk for becoming overweight

31% of females & 17% of males think they are overweight

52% of females & 19% of males are currently attempting to lose weight

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way around it.

▲ **The more popular teenagers are thin and not overweight.**

There is a school and societal “culture” that labels thin/not overweight teenagers as more popular and socially accepted.

Male: Yeah, there are a number of girls at this school that I can do that; I can put it halfway around from, like, her spinal column here, all the way around to, like, where her spinal column would be in her front—like half of her body.

Male: Those are the people that are accepted as popular. If you're underweight, then you're popular.

▲ **Underweight/anorexia is evident amongst teenagers and is considered a negative behavior, yet common.**

There were many references to the underweight teenager, especially the underweight teenage girl, who lives an unhealthy life as a result of weight perception and related diet and exercise behaviors.

Male: Yeah, I mean walking down the school hall . . . I mean going out into town, that's a lot different in Boulder County, because I go out to the stores, and it's like, there are people there who look normal. I mean, I define normal as in not Miss Nazi Death Camp Girl here who starved herself for five days so she could be as thin as absolutely possible, but I mean normal as maybe size 14 or something. You know they're not, you know, just huge massive people that weigh 500 pounds walking down the sidewalk, but you know they're not just unhealthily overweight. But here at school, I mean, it's scary. I mean there are . . . I swear there are some girls I can reach my hand halfway around their midsection because they're so thin. That's not healthy.

Male: And they still are convinced that they're absolutely fat.

▲ **Stress is a factor in influencing risky health behaviors, including drugs, alcohol, and eating behaviors.**

Teenagers recognized stress as a factor in their lives that influences their behaviors—many different behaviors as ways to cope with stress.

Female: As a whole, I think kids these days are a lot more stressed-out than they used to be, and I don't think anybody would start using drugs or alcohol if they were completely and utterly happy. Why interrupt something like that? So we're dealing with . . . I really think we're dealing with so much more than what we used to. Like, tests are getting harder, schools are getting harder to get into, parents are putting more stress on us over sports.
Female: Yeah, you have to be, like, perfect and, like, look perfect and be thin, and . . .

▲ **Obesity/overweight issues overlap with other risky health behaviors.**

The personal issue of weight and societal labeling can lead to other risky behaviors like violence and/or depression.

▲ **Time and money influence teen decisions about diet.**

Teenagers are busy and have a lot of restrictions on time, both in terms of amounts of time and the quality of how you spend your time. In addition, teens may not have extra money to spend on making healthy decisions regarding their diet.

▲ **The environment influences teen decisions about diet.**

Given that teenagers are restricted to certain environments (especially school) during certain times of the day, the availability of “good” or “bad” food choices is (at least partially) defined by what the school chooses to offer to its students. Fast-food eating options are available but often unhealthy.

Teen Solutions

▲ Although the task is daunting, addressing overweight/obesity needs to happen at the societal level.

Teens seemed overwhelmed by the magnitude of how to change the perception of overweight/obesity; drugs. At the same time they felt it was “do-able.”

Male: There might be ways to make people fit into society’s general opinion of what they should look like, but there’s no way to change society’s opinion of what they should look like easily.

▲ Address weight issues in the media by highlighting people who are a normal, healthy weight.

If people saw a different world (as portrayed by the media), a world where normal-sized people are the norm, then societal views might slowly change as well.

▲ Address the time and money issues around good diet choices for teenagers.

Change some of the environmental options for “good” food.

Male: Open, like, a trail-mix fast-food store.

Male: I mean, if there was fast-food that was affordable and a bit healthier, that’s probably what I’d be eating, but there’s not. Like . . . brightly colored fruit in the vending machines. I mean like that dried

fruit that was in here—that bright orange stuff—bags of that or bags of, like . . . just change, like, the menu so that there’s some stuff, and I’m sure that the people who wanted to change their body shape would eat that instead.



out of the way or something. But that can't always work when you're in a car, because cars are a lot bigger and there's not really anywhere you can go when you're on the highway, but you can go off the side of the road or into a ditch or something when you're on a bike.

▲ **Some of the contributing factors to unintentional injuries are addressed by ingrained behaviors or habits.**

The examples referenced were seatbelt use and bicycle helmet use—wearing a seatbelt has become a habit. Wearing a helmet is a decision.

Female: I know, for me, that when I put on my seatbelt, it's just pure habit. I mean, because, even if I'm driving from my front driveway to my back driveway, I'll be, like, I don't need to put my seatbelt on because it's just a block. So then when I pull up to the stop sign, because my house sits on the corner, I end up putting my seatbelt on. So it's habit; once you start, then it's hard to not do it. It's just something that you get used to doing, and when you get in the car before you take off, you put your seatbelt on.

▲ **Other people's perceptions of you might influence prevention behavior.** A factor in decision-making about prevention behavior relates to whether it

will affect other people's opinions about you. This can include appearance when talking about bicycle helmets.

96% of females and 93 % of males normally wear a seatbelt when riding in a car

54% of females and 43 % of males normally wear a helmet when riding a bike

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▲ **Unintentional injury sometimes overlaps with other risky health behaviors.**

There was reference to the influence of drugs as a reason for unintentional injuries or accidents.

Teen Solutions

▲ **Laws work to initiate/enforce good behaviors that reduce unintentional injuries.**

Initiate ways (e.g., laws) that would influence healthy habits to prevent unintentional injuries.

Unintentional Injury/Accidents

In the Teen World

▲ **Perceived danger or perceived immediacy of danger contributes to teen prevention behavior around helmet and seatbelt use.**

A teenager's perception of immediate or potential danger contributes to their use of a bicycle helmet or seatbelt in a car.

Female: I think that people just perceive danger more in cars than in bikes, and I think that people think they have a lot more control, too, when they're riding a bike, because they can see something that's about to happen, or if there's a car who's not paying attention to them, then they can make a move and get

Across Groups

Implications for Program Planning

As noted, this report has been divided into findings by health topic area and solutions that can be used in program planning efforts for each of the health areas of interest in Boulder County/Boulder Valley School District.

In addition, there were common themes that spanned all of the focus groups—themes that should help program planners for all health issues of interest.

Interventionist

One common theme, not directly related to each health topic area so not noted as such, was the fact that very few students in all of the focus groups were aware of:

- the existence of an interventionist in the school.
- the role of the interventionist.

People who had a “relationship” with the interventionist (e.g., one participant stated that he was friends with the interventionist; therefore, he felt able to talk with him/her) seemed to be able to access this resource more readily than those who didn’t. Others had stereotypes that the role of the interventionist was

limited to drugs or alcohol. Others thought that interventionists only worked with students who had been referred to them due to a risky behavior or event related to the behavior.

Male: I know that our interventionist here in school, she’s extremely helpful, but 90% of my friends have no idea who she is. Nobody knows what an interventionist is, what she does . . .

Male: We have an interventionist at this school? News to me.

Resiliency to “x” Risk Behavior

When asked the question, “What do you know or notice about teenagers who have been successful at NOT doing these behaviors?”, focus group participants repeated the same messages with regard to each of the YRBS-defined health risk behaviors. The following is a comprehensive “profile” of a resilient teenager as someone who has:

- experienced or knows someone who has experienced the effects of “x” risk behavior
- awareness of the effects of “x” risk behavior
- skills/knowledge of how to be and stay happy
- good communication skills
- good refusal/peer pressure resistance skills
- good coping skills

- good grades
- good values
- goals/can envision the future
- involvement with activities that don’t allow for risky health behaviors
- parental involvement/knowledge of teenage lives and activities
- internalized values that works for self (e.g., religion, internal strength)

Tips for Program Planning

to Address Health Risk Behaviors for Boulder Teenagers

There are two ways to look at tips for program planning:

(1) within the heading “Teen Solutions to Address “x” Health Behavior” for each health topic area; or more generally by

(2) examining the themes across all of the health topic areas. Table 2 summarizes the latter in a “tips for program planning” format.

Table 2

Area of Interest/ Potential Intervention Point	Tips for Program Planning or as Part of an Intervention
The Message	Make it clear, reality-based; bring in guest speakers who have had experience with the outcomes of “x” health behavior. Don’t lecture, don’t label people, spend more time on the outcomes. Build a reality picture so that teenagers can see outcomes in the immediate present.
The Messenger	Ideally, someone close to teenagers’ age or life experience or at least able to relate to their world. Person/medium must be honest and open, clear, and reality-based. Person must be aware of the world of teenagers and educated about the health topic area(s).
The Media	Recognize that the media is very influential in teenage lives—both in inviting risky behaviors and giving them the power to stop or not start risky behaviors. Find ways to use the media to address societal messages that contribute to unhealthy behavior. Address and/or add on to the “dreamy” side of the media—show outcomes; be real, genuine in the approach.
Teenagers	Develop relationships with teenagers that enhance understanding of their interests/issues. All conversations—both formal and informal—should be straightforward, genuine, and “open.” Teenagers are looking for people to be able to have open communication with in order to learn more about “x” health topic. Include teenagers in program planning.
Parents	Play a key role in teenager lives. Find ways to enhance communication and openness between parent and teenager. Show how early “values identification and clarification” can happen in the home. Parents can play a powerful role as messenger and social support. Parents must be aware and educated about the health topic area(s).
Interventionists	Increase role/recognition of interventionists in schools so that teenagers are aware of formal social support, open communication, and educational options for them as they make decisions about health risk behaviors and/or address existing health issues of concern.
Social Support	Friends, parents, other adults influence teen decisions and resiliency behaviors. “Who you hang out with matters.” Also, “someone to talk to” is very important. People in the role of social support givers should be aware and educated about the health topic area(s).
Cliques	Again, “who you hang out with matters.” Sometimes this is healthy, sometimes not. Investigate programs such as “Breaking Down the Walls” and other such ways to model that it is good to be exposed to new people, new perspectives, including perspectives that “x” health behavior is alright.
Multiple Health Topic Areas	Many of the seven risky health behaviors/issues overlap with each other, either in their influence or their cumulative effect. Don’t look at each health issue in a vacuum—consider interventions that address combinations of health topic areas.
Resiliency-Building	Most of the resiliency behaviors identified by teenagers could be applied to all of the health topic areas. Take note of resiliency factors when planning programs for prevention as well as intervention.

Table 2 cont.

Area of Interest/ Potential Intervention Point	Tips for Program Planning or as Part of an Intervention
Goals/Values Identification	Find ways for teenagers to identify goals and/or values (e.g., career, family, religion, sports, etc.) that are useful to help with immediate decisions about health risk behavior(s).
Stress	Find out the roots of stress in teenagers' lives and ways to address stress in school and community settings.
Activities/Venues	Find ways to get teenagers more involved in activities that will keep them from being tantalized by unhealthy behaviors. Consider teen values and interests when designing activities or venues directed at and for teenagers.
School	School is an environment that teenagers know—perhaps the best of all of their shared environments as teenagers. Include teenagers/their perspective in curriculum planning/decision-making, school-based program planning, policy/policy enforcement decision-making.
Community	Community-based activities are less represented in this report, probably because the setting of all of the focus groups was in the schools, which could have influenced the results. On the other hand, many of the insights learned from the focus groups can be applied to a community setting. Again, teenager involvement in community-based program planning will enhance the success of the outcome.
Environment/Society	Change for some of the health issues must occur at the larger, societal and environmental level (e.g., laws, restaurants, school vending machine decision-makers, Boulder County government etc.). Change might be slow, but it can happen, especially if it is reality-based. Recognize and factor into program planning that often the environment is the stimulus for health behaviors. If you want to change the response, change the stimulus.

Next Steps

The focus groups yielded useful information about the reality of the teenage world with regard to health risk behaviors, factors that enhance resiliency, and ways to address the prevalence of each health issue. The intention of the report is to share these findings with stakeholders (e.g., parents, school personnel, health department staff, community-based agency personnel, community members, potential funding organizations) who can use this information in a positive, proactive way to reduce risky health behaviors and improve health outcomes for teenagers overall.