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M: It is now 3:00 p.m. and we will go ahead and get started. If you have any questions during today's presentation, please submit them on the left side of your screen in the chat box. There is also a handout with today's presentation so you can copy that or download that and follow along if you'd like that as well. I will now hand things over to Lisa.

Unti: Thank you. Welcome everybody to today's webinar. Today's webinar is titled "Adolescent Suicide Prevention: An Introduction to the Risk Factors of Suicide and Resources for Vulnerable Youth." Today's objective that we're hoping that you get out of this webinar are to identify unique risk factors for suicide among native youth, identify risk factors for suicide among vulnerable youth, describe the impact of cyberbullying on adolescent social wellness and mental health, and identify resources for technical assistance.

Today I'd like to welcome our panel and our presenters. Today, we are joined by Labrita White, program manager for the Adolescent Pregnancy Prevention Program from FYSB, Family Youth and Services Bureau. We're also welcoming Tom Anderson, a senior strategist and consultant member of the Cherokee Nation, who is with the Tribal Public Health. And we're joined by two

folks from SAMHSA [ph]: James Wright, a public health advisor for the Suicide Prevention Branch, and Ingrid Donato from the Chief Mental Health Program Branch. And myself, Lisa Unti [ph], I'm with ETR. So I'd like to welcome now Labrita White.

White: Thank you so much. This is Labrita White. I'm program manager for the Adolescent Pregnancy Prevention Program. And I'd like to say good afternoon and welcome to our webinar on suicide prevention. We're absolutely grateful that you've taken the opportunity to join us to talk about this very important topic. But before we hear from our guest presenters who I'm confident that you will find to be both knowledgeable and very well-versed in sharing information about suicide prevention, of course they're experts, and I know that you're going to learn much from what will be presented on today and be able to apply that to the very important work that you're doing with youth across the nation and in U.S. territories.

So one of the things we'd like to do before the training actually begins is just to take an opportunity to help you make the connections as to the relevance of why adolescent social wellness and mental health matters to FYSB grantees. Additionally, I want to emphasize the importance of engaging in ongoing conversations about adolescent wellness and mental health. As you're aware, in June of 2017, we came together in St. Louis for our annual FYSB Grantee Conference. As a continuation of the conference theme, Strategies for Success: A Holistic Approach to Adolescent Pregnancy Prevention, there were a number of

connections from that conference that you can make with today's training, the presentations that will be given to the daily work that you all are a part of.

One connection is APP's programs often including ongoing conversations that address the socio-emotional, sexual and mental health and wellness of adolescents. That's one connection. Another connection is FYSB grantees are on the front lines and are directly involved in programs and services that touch adolescents in a variety of settings, including some of the most vulnerable youth. And as I stated, we're serving those youth throughout the nation as well as in our territories. Thirdly, FYSB grantees can play a critical role in identifying, supporting and referring youth at risk for suicide and other mental health issues. And finally, FYSB programs work with communities and programs locally that support adolescents to live a healthy, productive and violence-free life. And so those are definitely four important connections that we'd like you to draw upon as you participate in today's training.

So we appreciate you taking time to join us today as we learn more about what APP programs can do to support adolescent mental health and vulnerable youth. So at this time, I'm going to turn it over to our first presenter. But before doing so, I'd like just to share with you or ask you to join me in sharing some positive thoughts for those who are impacted by both Hurricane Harvey and Hurricane Irma. Not only have our youth been impacted that are participating in our programs, but also the staff of those programs. And so I just think it's important, especially even with today's topic that's related to mental health, that

we take a moment to pause and send some positive thoughts to those persons that were impacted.

But at this point, we're going to move forward and now turn over today's presentation to Tom Anderson. And Tom is a member of the Cherokee Nation, and he's going to discuss with us on this afternoon how trauma and suicide impact youth who are a part of tribal nations—are part of tribes, are among tribal youth. And so without further ado, I'm going to turn over today's training to Tom Anderson. Tom?

Anderson: Thank you so much. I appreciate the opportunity and I want to applaud the Family and Youth Services Bureau for being inclusive and reaching out for the American Indian perspective. My hope today is for you to—this is not to be an exhaustive exercise, but at least create an appreciation for some of the plights and some of the issues and challenges working with American Indian youth and working with American Indians in general. Another hope that I have for today is to cause you to be a little bit uncomfortable in a good way. The American Indian presentation I hope today will challenge you just a little bit because that's when learning begins.

What we're going to attempt to do here, we've got a few objectives. Hopefully you'll be informed and able to articulate contributing factors to Native youth suicide. I hope that you'll have a better understanding of the disconnect with many of the Natives leading to the highest racial groups of suicide, and maybe explore some of the reasons contributing to that high rate. My hope is you'll come to the understanding that a lot of the things that you were taught,

things that you hold dear and have learned and know about American Indians is largely untrue. Maybe not everything but we're going to explore a few of those. And you'll learn that Native suicide prevention program called Culture is Prevention is a successful and promising path for Native youth suicide prevention. So with that in mind, we'll move on to our next slide here, if I can get it moved here. There we go.

I'll show you a photo here and I want you to reflect on that for just a moment. To honor one is to honor all. If you look closely, if I would ask you what you see or what do you feel when you look upon this photo, my thinking is in general there can be a lot of pleasant remarks or comments to be made; correct? And what we can't see is down the road. We can't see if suicide is lurking in that young child's mind. We can't see if FASD, Fetal Alcohol Syndrome has some sort of impact and could be a leading cause of youth suicide. So I want you to kind of hold this thought as we move through these slides and think about young ones and their chances in life, both those on a reservation and those who are living in metropolitan and urban centers. Think about what you're doing and what we can jointly do to hopefully make a difference in at least some of these young people's lives.

Suicide looks different in the Native community than it does in the general population. Nationally we know suicides tend to skew middle aged and white, but among American Indians, 40% of those who die of suicide are between the ages of 15 and 24. I think that's worth repeating. Almost half of those who die of suicide are between the ages of 15 and 24. And among adults ages 18 to 24,

Native youths have a higher instance than any other ethnicity and higher than general population. I'm going to have a graph here shortly to put up. American Indian suicide impacts all. Suicide is the second leading cause of death, behind unintentional [ph] injuries, for American Indian youth, again 15 to 24. And a significant rate of American Indian and Alaskan Native youth impacts entire communities, the tribal leaders, families and the youth themselves. Everybody gets concerned. I have had personal experience from tribal leaders that come to me and ask me, "Tom, we've got suicides going on in our youth. What can we do? Declare it an emergency on the reservation or the tribal jurisdiction to try to call the attention to what's going on."

[TECHNICAL COMMENTS]

Anderson: But anyway, we'll be getting to that. Here is a chart that was produced by CDC. It's available on CDC wonder at the bottom. But one of the things I want to call you to is looking over on the far right, you'll see American Indian and Alaskan Native, and look at the blue column where it's demonstrating American Indian males. Look how much higher the rates are for American Indian males. I share that with you that American Indian youth and 18 to 24 are hurting. They're leading the group.

[TECHNICAL COMMENTS]

Anderson: What we want to try to do here is draw your attention that the green bar on the far right is combined males and females. And you look across the board, the red column, American Indian women lead all categories as does males, and obviously both we have higher rates. The point to take away from this is that you don't have

to live on a reservation. You can be in the urban centers. You can be in a rural setting off of a reservation. American Indians have a high rate and we're going to explore why is this. What's going on? Why are American Indians suffering such terrible rates?

And as we look at the challenges behind suicide, we obviously look at data. Data on American Indian deaths are inexact and we have issues with people identifying as American Indian or Native American. When we look at census data, 5.4 million people identify themselves as American Indian, but not all of those people are on a roll or recognized by the federal government as a member of a federally recognized tribe, and it gets to be cumbersome. And as we'll demonstrate here in a few minutes, remember American Indians are the only racial group to have to prove it. They have to largely prove that they're a member of a tribe. They do that through the Bureau of Indian Affairs through blood quantum.

So there's a lot of misunderstanding where people can look to be American Indian, however they're not because they're not enough blood quantum of one tribe or multiple tribes to be a member. That is a contributing factor. But all in all, what we're going to learn is even with the rates being terrible, it still may be under counted, and we think that it largely is. And maybe we can explore that.

Here's a photo that was taken at the Smithsonian Museum of American Indian. I want to try to share with you some perspectives in the Indian mind. Here's just a saying by Angela Gonzalez. "Being an Indian is not about being

part of something; it's about being part of something." And I think that that's kind of a nuance, a subtly to understand, but maybe we'll get through that _____. I want to share with you American Indian Alaskan Natives have certain legal rights that other minorities and other population groups don't have. And they were given this promise of proper care and protection by the federal government.

And I want to digress for just a moment. I want to share with you that before there were Europeans, before there was colonization, American Indian tribes had treaties and agreements with foreign governments, Spain and England and other foreign powers. And largely, these rights and promises for our government as it exists today were not freely given to indigenous people; rather they were exchanged. And typically it was ancestral lands and natural resources that were traded. And three things that were typically given in promises were housing, education and healthcare. And as we look at American Indian people's health disparities, including youth, you see they lead almost every group as far as bad outcomes.

So I'm not saying that anyone's [ph] to point to failure at excepting for Congress. They haven't provided adequate funding over the decades. American Indian is a population group required to prove they're a citizen. Again, it's through the federal government mandate. The Federal American Indian Policy resulted in governmental trust responsibilities for American Indian people of education, housing and healthcare. That's just a reiteration of something we shared earlier.

We think of healthcare in the linear mode, whereas American Indians see it as a circle. And this is an example; I borrowed this from one of my Great Plains Tribal Leader Council's friend regarding the four parts of wellness or a medicine wheel. I just want to let you know it's like an oval in this picture but it's actually circular. And again, our intent is not to bring you every message, every nuance of American Indians today, but at least arouse a new awareness that you may or may not have. Included in that indigenous world view, I thought I would share a couple of concepts that maybe is different when you go out working with American Indians or working with youth.

The American Indian and Alaskan Native view contains thousands of years of ancient wisdom of how to live on earth. And this is these lessons, these lectures, these messages were typically transmitted through oral tradition, oral histories through storytelling. So you see often when you deal with American Indians having something verbal is a great way to communicate rather than handing them a pamphlet or some other way. You may want to consider having a story or trying to share things as one way, as a priority in community.

Another indigenous view is high priority is given to loving the earth, preserving the earth, honoring the earth and developing [ph] technology to benefit people while protecting the earth. The earth is a central value to everyone. And this is a foreign concept to a lot of us, but it's an important concept and maybe we can demonstrate it a little more exactly here in a slide or two on how that relates. Another important concept on the indigenous world view is often they work in two worlds, an expression that the people have an interpretation of their history

and their community that is specific to their own [ph]. Remember, there are 567 federally recognized tribes. There are actually more groups than that. There are many state recognized tribes that are not necessarily part under the federal guidelines. And each of these tribes have their own ancient history, their own stories. So the old cliché, when you work with a tribe, you work with a tribe because each one offers different understandings, different beliefs, largely. Although many are similar, there are dramatic differences between them.

And there's also a dramatic alternative interpretation of the world and of reality, and we can get into that. But multi-culturalism, multi-world views, multi-cosmic nations and even multiverses, rather the universes, are thought more appropriate in the Native world than a single universe strategy that we're taught as we're brought up. Respect and appreciation of other's world views and religion is a general feature of American Indians, and I think that's been perpetrated throughout the eons and the centuries, even with colonialization.

A couple of concepts that I'd like to share with you are some words of some prominent leaders in the past. One was Chief Joseph in Oregon and Washington. At one point he was asked to [INDISCERNIBLE] wanted the lands and his response to the Army at that time was, "My friend, we don't own the earth. The earth owns us." Again, going back to this concept here, the earth and myself are of one mind. I share that because you fast forward from 1887 to today, and you'll find a lot of that still—that feeling or thoughts resonate through today.

Here's another saying regarding the earth, and I'll let you read. As you read this, just keep in mind that we're all writing our own life story, and I

challenge you to include in your life book an awareness of the American Indian plight. And maybe you don't know what it is, but I challenge you to learn. At the outset I suggested that maybe the stories that you've learned maybe are untrue. It is given with a slight bias and when you really delve into our history rather than a sanitized version, you see that maybe it is substantially different than what you thought it was. We all have the capacity to do something better for American Indian health and the health outcomes, and this concept that I'm sharing with you today will hopefully offer some of that insight.

And a generational term is something that I want to share with you today. You probably had some concept of what this was, what this refers to. But American Indians experienced massive losses of lives, land and culture from European contact and colonization, resulting in a long legacy of chronic trauma and unresolved grief across the generations. And there is good science behind what I am sharing with you today. SAMHSA and a lot of the other divisions of HHS have funded some tremendous articles and some grants that resonate what I'm sharing with you here. The phenomena labeled historic unresolved grief or historical trauma contributes to the current sociopathology of high rates of suicide and homicide, domestic violence, child abuse, alcoholism and a whole host of other social issues among American Indians.

So if you're not familiar with this term, I challenge you to—there are volumes, there's tremendous studies out there that suggest that maybe you write that down, jot that down and inform yourself of that. The concept of historical unresolved grief and trauma of American Indians is exacerbated by historical as

well as present social and political forces. We do have some information regarding Jewish Holocaust survivors and the children that have been used to delineate intergenerational transmission of trauma grief and survivor's complex and then interventions based on traditional American Indian ceremonies and modern Western treatment modalities for gauging [ph] and healing those losses can be combined.

So I'll just share with you that when we're talking about American Indians or Alaska Natives regarding their historical perspective, we need to make sure that there is something underlying beyond all this as well. Here's another slide that I wanted to share with you; it reemphasizes a lot of the points. Community impact of suicide, how it's felt, how grief—psychiatrists have shared this with me that suicide, it does impact tribal communities and youth suicide in particular. You remember we began this series, these youths are the ones that the ancestors, the ancient ones prayed for to have a better understanding. And some of the tribes I've worked with in the past, they don't even have a word for suicide in many of their native languages.

[TECHNICAL COMMENTS]

Anderson: Let me go back for just a second and share with you a program called Culture is Prevention. It's a youth suicide prevention program. There is a webinar and some other things coming up on that. Here are some resources that I suggest that you write down or they'll be in the slide deck if you download those. And as I leave this last slide with you, I would suggest that how we make others feel about

themselves says a lot about you. So with that in mind, I conclude today's presentation, and I'll turn this over to Lisa. So thank you.

Unti: Great. Thank you, Tom, so much. Okay, let's make some connections from the field. If you all could please respond, and they are responding now. You all are quick to the poll about the youth that you're serving. And it looks like we're getting results in. Thank you all for responding. And again, this is just not to be illustrative of all the different youth that are being served, but rather a snapshot of the youth being served by those of you participating on today's webinar. So look at the range of all the youth that are being served. It looks like youth exposed to trauma, a great number of you are serving youth exposed to trauma, so hopefully the information today will be relevant for you. We're teetering across quite a few different vulnerable youth populations.

[TECHNICAL COMMENTS]

Unti: I think we are ready to go ahead and move along and I would like to welcome our next presenters, James Wright and Ingrid Donato. So I will pass it over to you now.

Wright: Great, thank you and thank everyone for participating today. It's an honor to be on. I also want to make mention for those that are not aware that this is very timely because it's National Suicide Prevention Week in the United States. And last Sunday was Global Suicide Prevention Day. It's great that we're having the opportunity to be able to talk about this important topic. I'll be obviously joined with the chief of the Mental Health Promotion Branch, Ingrid Donato. So we'll

be talking both about suicide and then the relationship between suicide and bullying and cyberbullying.

We just learned from SAMHSA that this presentation does not necessarily reflect the views of SAMHSA or HHS. So I do want to go in a little bit of background first and talk about some statistics and some disparities. Suicide is the second leading cause of death for this target age range from 10 to 24, and actually it expands out past 24. In 2015, almost 5,500 youth between 15 and 24 died by suicide. And if you look you look in any of the YRBF data, you see that it's pretty prevalent; 18% seriously considered, 14.5 made a plan, 8.5 attempted one or more times, and then almost 3% made an attempt that had to be treated by a doctor. And it's primely of this as well because we're going to look at a little bit of the disparities, but we do know that girls are more likely to attempt suicide; boys however are more likely to take more lethal means.

So when we looked at 12 months before the study, 30%, and that's a huge number, almost one in three students nationwide felt so sad or helpless almost every day for two or more weeks that they stopped doing some of their usual activities. And so this is coming across the high school age range. And the prevalence was higher almost 40% for females than it was for males. We do know, as noted, the suicide rate is high amongst American Indian and Alaskan Native, one and a half times the national average for the age group. And this was telling, of all five, other than the deaths for the males, all five suicide-related behaviors were higher amongst females, all of those that were represented, and then the highest overall age range, I'll let people take a look at this, but were

Hispanic females. And that was true in every category except deaths. This is important because while deaths are critical, there's roughly 45,000 deaths per year, there's many, many more times that in attempt, so many, many people affected by this.

What are some of the risk factors? And there are many different risk factors and we can link up some of the resources that will show you some of those risk factors. But a couple I wanted to highlight specifically for this group, some of the biggest ones are hopelessness and helplessness. History of trauma or abuse, especially with youth, loss of relationships; and then what we're seeing more and more across the United States are local examples of clusters of suicides, so working on contagion.

SAMHSA, for those that don't know, again, we're the Substance Abuse and Mental Health Service Administration. We have eight major suicide prevention components. Garrett Lee Smith—and these are all grants—Garrett Lee Smith State and Tribal Suicide Prevention Program, which I'll talk a little bit about. We have a campus program. We have a national strategy adult suicide prevention program. The National Suicide Prevention Lifeline, which I'll give a little bit more information for, our crisis center follow up grant program. The Suicide Prevention Resource Center, which is the nation's only federally funded suicide prevention technical assistance center, Native Connections and Zero Suicide.

I wanted to highlight the purpose of the GLS because it does really cut across this age range of ages 10 to 24, and it looks at cutting across a number of

different sectors with the ultimate goal to reduce death and nonfatal suicide attempts. We've been really focusing lately on this idea of care transition, so what happens once an individual is identified as being suicidal or having suicidal behavior. The impact of Garrett Lee Smith will be shown in a second but I do want to show that all states in the nation have received this and the majority of states, it was over 90% focused on middle and high _____ so middle and high school training.

So how are we doing with this? We actually did do an evaluation study. We have a contracted evaluator. And they wanted to look at the impact over time. We've been doing the GLS program since—we're on our 13th round of funding, so I believe it came across in 2004 originally. This program, we wanted to know is it making an impact on the target population? Now not a lot of deaths occur compared to the total deaths for the year in 10 to 24, but we did want to see what kind of impact is it having. And when we looked at counties that were implementing GLS activities versus counties that were not implementing it, so most of these were gatekeeper trainings, what we found over a four-year period, 2007 through 2010, that more than 400 deaths were avoided between this time frame when we looked at it. And of that, like I said, 400 is important, but more than 100,000 attempts amongst those youth ages 16 to 23 were avoided during this same time period. So I think that's critical to look at the amount of lives that were impacted by the activities that are being implemented across the United States.

But there was some issues with what we found. One of the key findings was that these findings were only statistically significant for a period of one year, which means that the only way to continue to have those reductions is to continue providing that training and those resources. So it really requires a sustained public effort. Rural communities seem to be more effective, which makes sense. If you save a life in a rural community, it's probably going to have a significant impact on your numbers versus an urban community if it's the same amount. We also saw that gatekeeper training should be part of a comprehensive suicide prevention program, so not a one and done.

One of the main grants we have for suicide prevention coming out again is the National Suicide Prevention Lifeline, and I'm going to challenge every single person on the webinar today, if you do not have this number written down, put in your phone and sharing it, please do so. It's 1-800-273-8255 or TALK. It's a network of 160 independently owned and operated crisis centers across the United States answering this. So we route the call based off of the geographic location to these centers for anyone that calls with a suicidal crisis or emotional distress. And this call since launching in 2005 has seen—has taken over 7 million calls to date. And I just actually found out yesterday that the total call volume if we look at calls answered in 2016 was 1.5 million. The total call volume in 2017 is looking like it will cross 2 million calls. So over a quarter increase in one year, and that came from a number of different reasons, but promotions such as individual, the logic release for the VMAs and others have really impacted the numbers and the demand for the service.

And so we do have regional backup capacity to ensure that these calls can be answered. And we also added chat services online, so people if you don't want to call can go online and chat with a counselor. Why did we do this? It was interesting, we obviously know there's a demand especially among youth and people that don't want to engage over the phone. The thought is that it creates and kind we kind of coined this phrase, the online dis-inhibition effect. The challenge as a clinician myself, the challenge the notion of empathy almost—rapport, not empathy but rapport building because what we would get in a chat is an entire life story with higher acuity right up front. People are begging, you had a little bit more anonymity, and so we saw that people were coming online and sharing much faster their story and having a lot higher acuity of chats. So we felt that this was something that we had to engage in. Unfortunately, we're not able to provide text at this point. We did pilot it originally. But there are a number of individuals providing this service. Many of them are state-based and then there is also the Crisis Text Line that is national-based. And so we did with this chat again create nationwide response in 2014, and people are using it as follow-up.

But this is the one stat that I wanted to share, that 75% of the individuals that chat are under the age of 29 and many of them are under the age of 20. And they're also again the highest risk group that we have, much higher than our phones; 53% of those entering chat report current right then suicidal thoughts with an additional 27% in the recent past. So we know that that's a very high-risk time and population that we're reaching. So with that, I want to turn it over to my colleague, Ingrid Donato.

Donato: Thanks, James. And Tom did a great job in orienting us to the issues related to tribal youth. James has just given us a wonderful overview about suicide and some of the wonderful resources that are available to you as you're working with adolescents. And I want to take a little dive, a deeper dive into a particular risk factor; that is cyberbullying. And so I'll go a little bit about what you need to know, what you need to be tracking on, but I have a suspicion that all of you who are participating have a lot of—realize that cyberbullying is an emerging and concerning issue for our adolescents.

So I wanted to start at the beginning. So what is bullying? Bullying is aggressive behavior between youth that involves a power imbalance. So this is really a situation where one youth is trying to belittle or feel more powerful than another youth and is repetitive or has the potential to be repetitive. Cyberbullying is bullying more specifically that takes place using electronic technology. And you'll see this in some of the reporting systems, especially out of CDC, that they'll call it electronic bullying and not cyberbullying. It includes stuff that occurs on devices including cell phones and computers and your tablets, as well as on social media sites and text and chats as well. And one of the areas that I want to make sure that people are tracking on is that cyberbullying has taken place on gaming platforms as well, so something to be thinking about that we may not consider when we're working with adolescents.

We say it starts on Twitter the night before and ends up in school the next day because another thing that we really need to be remembering is that kids who are being cyberbullied are often being bullied in person as well. And those kids

who are being cyberbullied have a very hard time in getting away from the behavior. Cyberbullying can happen 24/7; again, another important reason why it is so concerning. It's not something that kids can easily get away from as more traditional bullying has. And just deleting those inappropriate or harassing messages or texts and pictures can be difficult because as it's going out in the cyberworld, it can go viral very, very quickly. So you have the potentiality of a situation that may have been in more traditional bullying occurred just between two kids or maybe a small group of kids can now be spread across an entire school or a much larger population than in more traditional ways when you're thinking about cyberbullying. And it hangs out forever.

So I want to go over a little bit of the statistics. So when we're looking at, we're tracking on cyberbullying, it's hard. But we use two typical data sources, ones that you're probably familiar with. The Youth Risk Behavioral Surveillance System, which comes out of the Centers for Disease Control Prevention and the School Crime Supplement, which comes out of Education and Justice. So the YRBS we find that about 15.5% of kids were experiencing cyberbullying or electronic bullying. And the School Crime Supplement has a different number at 11.5. And I put this up here because it's important, especially when you're working with adolescents, to see that there's a difference in that number.

The YRBS is really tracking on high school kids where the School Crime Supplement is tracking on middle and high school. So typically with traditional bullying, we see it peaking in middle school. However, that's not the situation that we're seeing with cyberbullying. This is really happening in high school and

with those older adolescents; another important reason why I'm so grateful to having all of you on the webinar who are working with adolescents who are interested and are invested in helping these kids.

So research on cyberbullying is tough. The research is growing, however, because kids' technology changes so rapidly, it's really hard for us to design surveys and capture those trends because we see Facebook and Twitter and Instagram, those are kind of consistent. But we're seeing these anonymous apps where a lot of this real dangerous cyberbullying is taking place like AfterSchool or Brighten or Yik Yak, Whisper or ASKfm. Those are constantly changing and they're anonymous. So once you kind of get a hang on one of them, there are new anonymous apps that pop up.

So I was looking at your survey results about the vulnerable youth that you're working with. I didn't include it in the statistics, but I see that a number of you are working with our LGBT youth, and I'm sur you know this, they are at far greater risk of experiencing bullying and cyberbullying than non-LGBT youth. So a very important consideration to be thinking about. And those of you who are working with our wonderful Hispanic youth, I know you're tracking probably as closely as I am on those rapidly increasing rates of major depressive episodes that our Latina girls are particularly experiencing. So very grateful that you're interested in this topic.

I want to talk a little bit about how you as an adult working with adolescents can understand the warning signs. And important thing to be considering is that these kids are not going to be coming to you telling you that

they're experiencing cyberbullying or bullying in general. Kids are not. We're finding this not only from the research, but when we're talking to kids and we're talking to parents as well. Kids are very embarrassed that this is happening, this is a shameful experience, this is a traumatic experience. And very, very concerning that we're hearing loud and clear is that they feel adults don't know what to do and they can make the situation worse. So it's really so important for us as caring and invested adults to understand what might be happening so we can be making those overtures to help open those conversations.

So those kids who are experiencing cyberbullying, here's some things that you really want to be thinking about. They stop using their devices. These kids usually have them on their hands 24/7. They appear nervous or angry or frustrated after using their devices or being online. they're not telling you what they're doing online. So maybe they would have been more engaged about especially those gaming apps, telling you what's been going on, and all of a sudden, they're quiet. That is a pretty important consideration. And they're becoming secretive and they're desiring to spend more time with their parents or a trusted adult rather than their peers. So of course it's always great that we're having these kids spend more time with us, but if you're seeing they're avoiding their peer group, that is a warning sign.

And for those kids who may be cyberbullying others, there's a couple things that you want to be tracking on. If they're switching screens, they're hiding their devices when adults are by, that's a warning sign. They're using their devices late at night; again, we work with adolescents, they use their devices late

at night, so really how are they experiencing differently? Are they laughing excessively? Are they laughing in ways that may not be a, "Hey, this is all great," but really maybe they're engaging in some cruel behavior. And you know it, you're working with these kids, you know what that might sound with. And you're also noticing an increase in sensitivity towards their peers. So what's happening in the cyberworld is emboldening them to exhibit these behaviors with their peers outside of the cyber space. And they may appear overly conceited about their text skills and abilities. So track on these signs so you can be making those overtures to kids if you are seeing these.

So why should we care about bullying and about cyberbullying? Because kids who are experiencing this have profound effects. These are effects that happen immediately and they can be long-lasting as well. This is a traumatic experience, so those who are experienced with working with kids who have been exposed to trauma know that it affects them now and it's going to affect them way klong down the road. So the kids who are being bullied, you're going to see increased rates of depression and anxiety, you're going to see increased rates of somatic complaints. They're going to be saying they have headaches, they have stomachaches, all of those sorts of things.

You're also going to be seeing decreased academic achievement. Why? Because these kids do not want to go to school. They don't want to be in these toxic environments. And as I had mentioned earlier, those LGBTQ kids that we care about so much are at far greater risk of being bullied than other kids. Those kids who bully others also we need to be tracking on and intervening with very,

very closely. These are kids at greater risk for abusing alcohol and other drugs, getting in fights and vandalizing, engaging in early sexual activity, very important, with the group that we're working with, and that I'm talking to today. And in the long-term, we're really seeing that they are at greater risk for being abusive towards their romantic partners, spouses and their children as adults. An incredibly important thing to be considering why we should be taking this very, very seriously. And those kids, those bystanders are also experiencing increased risk as they're seeing this happen, even though they're not actively participating, it is affecting them as well. They are having an increase in use of drugs and alcohol, increased depression and anxiety as well, and they're going to be more likely to skip school, too.

Those kids who are both bullied and bully others are the ones that we worry about the most because they are at the greatest risk of all of these kids for suicide. So every important consideration for this population. I know that many of you are working with kids who are trauma exposed and I wanted to let you know about a study that came out in 2015. You may already know about it. Lereya, Copeland, Costello and Wolke, which looked at thousands of kids and found that being bullied by their peers in childhood has worse long-term adverse effects on their mental health, on young adults' mental health than being maltreated by adults. So kids who are being bullied by their peers have worse outcomes than those who are being physically, sexually abused and neglected by an adult. That is an important finding that really made us pay attention to the importance and really drove home the importance of this work.

So I want to talk a little bit about the complexity about bullying and suicide. And there's a number of studies that we have on this slide that I want to bring to your attention. We hear in media all the time, this youth died by suicide because they were being bullied. And after the next couple slides, I want you to be thinking about that a little bit more sophisticatedly and I want you to think about it a little more deeply than what we hear in those news clippings. So we know that victims and perpetrators of bullying are at a higher risk of suicide than their peers. And as I mentioned earlier, those kids who are both bullied and bullying others are at the highest risk. All three of those groups are more likely to be depressed than kids who are not involved in bullying, and depression is a major risk factor for suicide. And again, we see this reiterated in this final bullet here, which have more of those studies that's driving home that bullying is associated with increased suicide risk in young people.

However, I want to bring to your attention another study that came out in 2011. This is not a small study, as you can see there, nearly 4,000 kids, that look at the association between bullying and suicide and said that it appears to be largely explained by other influential characteristics. So they say in the relative odds—that in the study they were noting that the relative odds of recent suicide ideation are three to four times higher for those youth who have been bullied in the past year. However, in their study, they found that once those related factors, self-esteem, depressive symptomatology, course of discipline are taken into account, that association between bullying and suicide is no longer statistically significant and this was true for both boys and girls.

So what do we do with this information? We want to make sure that we're tracking on those other important risk factors that can plan an important critical role. We're going to be looking at family history of suicide with the adults or if there is abuse already. We're going to be looking at history of depression or other mental illness, substance use issues. We're going to be looking at if they're isolating. And as James mentioned, we're going to be looking at those local epidemics of suicide, and incredibly important as we're seeing more and more in the suicide literature, easy access to means, the ability to do it. With all that in mind, we want to think, remember that here is a difference between causality and correlation. There is a strong correlation between bullying and suicide. There is not a clear causality. So bullying is an incredibly important risk factor to consider for suicide. I lost my slides here, but we want to make sure that we are tracking on that. Not everyone who is experiencing bullying is going to be suicidal, and to really be looking at the whole picture when you're working with children who are experiencing bullying. So is it important to be tracking on bullying and addressing that? Absolutely. But you don't want to stop there. You want to make sure that those kids are getting into treatment if they need it, you've got to make sure that there are other factors that might be going in the home and school environment that may not be related to bullying but that be exacerbating the situation. And you really just want to be taking home the message to really be looking at children and the whole picture.

So as you as adults, what do you do, especially with cyberbullying? You want to be taking it seriously. You want to be proactive in having these

conversations with those kids. You want to be encouraging documentation, taking those screen shots, and engage social media reporting mechanisms. Facebook has a mechanism that kids or even adults can be tracking, click on I don't like this post, and will go through a whole series of things that adults and kids can do to report if they're being cyberbullied as does Twitter. You simple click on they are being abusive or harmful, and you walk through the mechanisms as there.

And so in my remaining time with you, I'd like to go over some concrete resources that are available to you. First, SAMHSA developed in addition with the federal partners in bullying prevention an app. This is a free app that's available to Android and Apple markets that's really geared for the adults who work with adolescents. It is full of resources at each stage of bullying. So how to stop it on the spot, how to understand the signs and symptoms, how to refer kids for care, all the legal ramifications; all of those sorts of things. It also has conversation starters, so really what might seem like innocuous little questions to talk with your adolescent to develop that strong relationships that's going to be protective not only with bullying, with all other sorts of terrible things that these kids may be experiencing.

And SAMHSA works very closely with many, about 26 different federal agencies across the government, and has developed and supports a website called stopbullying.gov that has lots of resources available for all stages of this. And there is a brand-new section that's going to be released very soon specifically on cyberbullying with enhanced material. So follow stopbullying on social media.

We're on Facebook, Twitter, Tumblr, Instagram, Pinterest. We're not on Snapchat yet but we're going to get there soon. We're on govdelivery and we are going to give you regular resources and research and information at the ready for you.

And train yourself. On stopbullying.gov is the bullying prevention training center. This is an online course that you and your staff can take that will walk you through what you need to know about bullying and bullying prevention. And there are CEUs attached to it, so if you are looking for credits, take this course and you will be able to take credits for a whole number of disciplines. We worked with the Centers for Disease Control Prevention to develop a resource on the relationship between bullying and suicide. This is available, there is—oh, the link is not on our slide, but I can put that in the chat for you. It's available on CDC's website that will help you with more information.

We also have in addition to the no bullying app, a suicide prevention app. This is an app for clinicians on how to use the SAFE-T [ph] approach to suicide prevention. It goes through case studies, it goes through conversation starters, as well as treatment options and referrals. So it's going to go through a five-step evaluation and triage on what to do when you are working with someone who may be suicidal. And there are plenty of resources related to the National Suicide Prevention Lifeline that are available to you through SAMHSA's store and through the Suicide Prevention Lifeline, including wallet cards and magnets and all sorts of tailored resources about that. James, did you want to say anything more about the suicide resources?

Wright: No, just that they are available and that anyone that wants to get a hold of some of these, we are reissuing some prints, so you can get that on the SAMHSA's publication site. That's about it.

Donato: Great. So this is a complete shameless plug for me, solely because I'm on the webinar with you all.

[TECHNICAL COMMENTS]

Donato: I was going to tell you about a resource that we have called Depression in Mothers: Not More than the Blues. This is a resource available at samhsa.gov that is a toolkit for working with girls and women who are experiencing maternal depression. These are wonderful steps that you can take as laypeople to help address and stave off and combat those symptoms of maternal depression, which we know is another important factor to be thinking about when we're addressing suicide prevention in this important population.

So that is it for me. I'm going to pass it on to Lisa. Very thankful for this opportunity to talk with you all. Thanks, Lisa.

Unti: Great. Thank you so much, Ingrid, James and Tom. We're nearing the end of the presentation piece, but we want to hear from you one more time. We'd like to get a little bit more activity from all of you and your voices in the field. If you could respond to the poll question and just tell us a little bit about the types of activities or efforts you're implementing within your programs and your communities to address suicide prevention, social wellness and mental health in your programs. Take a moment to do that. I'm looking at the questions and then we're going to move into a question and answer period. So if you haven't had a moment to type

a question in the chat, please do so and we'll be pulling some of those questions and then opening it up for additional questions for our panelists.

Some responses are coming in to our poll. It looks like a variety of things are going on in your programs from parent awareness, there's some outreach program, Wyman Teen Outreach [ph]. And here, helping young people with social and emotional health [ph]—moving faster than mental health training, trauma informed training. So this just gets us to see again, it's not an illustrative list, I'm sure, but to see the range of all the different types of activities and efforts that you were all involved in. This is great. Continue to type in your responses. And again, if you want to type in a question into the chat box, we are going to go to that in just a minute. Thank you all for participating.

And the nice thing about the range of activities and efforts that you're all sharing here is we will be summarizing this information and sharing this information back with all of the participants so you can see the range of activities that are going on. I think we'll go ahead, we're starting to get some repeat of activities here. Very impressive. Very nice range of activities that are going on in your programs. So we're going to move now to take an opportunity to answer your questions and for you to ask additional questions. I'm going to look at a few of the questions here and I'm going to offer them to be panelists to respond. So Ingrid and James, it looks like there was a question that came in asking where are the youths from that you're doing research on. I think that is a question about some of the data that you were responding to.

Donato: Well, this is Ingrid. The ones that I was referring to, I was referencing national/international studies. So I'm not conducting the research, these were studies that were conducted by researchers in the field. But I know James may have a more specific answer about the GLS evaluation that they're conducting.

Wright: The GLS evaluation actually came from our external evaluation and the slide actually showed the study. But we can also share, you can Google it for the Garrett Lee Smith evaluation findings. The statistics were primarily from YRBS, the CDC WISQARS and those gave mortality data and attempt [ph] data also come from SAMHSA's NSDUH [ph] data.

Unti: I see a number of questions asking about the mental health training or where they can find the mental health training site that was referenced.

Donato: The bullying prevention training can be found directly on stopbullying.gov. You can find it under the resource center and you click on it and it's a self-guided training course. And there's a quiz that you take the CEUs, it'll give you all the information attached right there. So find it on stopbullying.gov.

Unti: Again, those links that were provided are also available if you are able to download the slides from today's presentation. I see another question here that really could go to any of the panelists. Tom, let's see if you have a response for this. One of the participants explained that they do pre and post surveys, and what would be appropriate questions to ask concerning suicide, bullying, social media use and loneliness from generation—it looks like I here. I don't know if you have something that you want to recommend, Tom, and then we'll go back to James and Ingrid, if there's any surveys or scales that you recommend.

Anderson: Well, thank you. There are a number of resources out there. When you get into surveys, it depends on the type of survey you're going in, so that's kind of an open-ended question and until I have a little more information, I wouldn't feel comfortable in doing that. But there are a number of resources; SAMHSA has an abundance of resources. Sorry I can't be more specific.

Unti: Ingrid or James, do you have any additional thoughts?

Donato: This is Ingrid. I'll jump in and then pass it off to James. I have a charge for you, and I think it's from Joseph [ph], if you could let me know what state you are from; the reason why I ask is there are a number of states that have identified specific bullying-related measures that they're tracking on and aligning your efforts with what's going on with the states would be fantastic. This is an effort that's going on through HERSA and I'll try to dig up the link and post it in the chat if I possibly can. But I would highly recommend that. It's through their—I'll try to get the information and pass it on to the chat.

I would also suggest that you use our National Registry for Evidence-Based Programs and Practices. This is a wonderful—they have a new learning center there. This is another opportunity to get technical assistance around data collection as well, and survey and indicator selection [ph]. And James, do you want to talk about SPRC?

Wright: Yeah, but if you can, just can you please repeat the question one more time because I want to throw in SPRC but I want to be mindful of specific things in SPRC.

Unti: The question was the participant was saying they do pre- and post-surveys, and were asking about appropriate questions to ask around suicide, bullying, social media use and loneliness. And then there was a follow up from this participant asking for—they said IRB-approved surveys; I'm interpreting that also to mean validated maybe nationally used survey items and scales. Is there a compendium or as Ingrid was saying, an item bank that they can go to?

Wright: There's not, but what there is, when we look at SPRC, obviously with loneliness is an additional risk of loneliness and isolation being an additional risk factor. All of the states have received Garrett Lee Smith and some of our other funding, and in that is a requirement for that type of data collection. They've been working with grantees on doing surveys and how to most appropriately administer them and get the highest rates of return on them in a number of different areas. And so we can ask them, but anyone can ask for technical assistance from SPRC. And they also have materials related to suicide and bullying. So that would be the first place that I would start is actually requesting assistance from SPRC directly.

Donato: Can I chime in because I had another resource that I just posted in the chat. When the definition came out, there's a lot of work led by CDC about defining bullying. And in that, they have a whole slew of resources around recommended data elements for data collection and surveillance. I just put the link on that resource in the chat.

Unti: Great. Thank you for the reminder, Joseph for acronym use. What is SPRC, James?

Wright: Sorry. That's the Suicide Prevention Resource Center. Their web address is sprc.org.

Unti: Thank you. I have another question that really I think can go to all of our panelists, so let's go back to Tom first and then go back to James and Ingrid. The question is we do healthy life skills workshops for youth. Do you have any activities and/or PowerPoint presentations to do with teenagers specifically? So Tom, talk a little bit maybe about Native use specifically, and then more broadly we can go back to James and Ingrid.

Anderson: Sure, thank you. Great question. There is a program called Culture is Prevention, and it talks about—the program is about preventing youth suicide. I'd be glad to share, I think I posted my email. If you'll email me, I will send you some specific resources that are downloadable. Anyway, the Culture is Prevention of Suicide was a program that we were involved in here in Oklahoma with four or five tribes, and the rate drops were so dramatic, the Surgeon General wanted to know, "What are you guys doing down there with Indian youth?" He arranged a meeting. So it's quite a successful program that can be broadened not just for tribal youth. But I'd be glad to share that with you, so thank you, Lisa.

Unti: Just as a reminder, your contact information is on the slides and that will show up momentarily. And so James or Ingrid, do you have any additional suggestions for resources around working with teenagers specifically?

Wright: Well, again, I know a lot of our programs or at least our grantees have done this, and while we have worked really on the national level, I think linking up with what the states have done specifically is going to be the best option, so finding out

who's your state contact. The good thing about that sprc.org website is it has the it broken out by states. You can identify who is your for example suicide prevention lead for the state, who would know where the funding is and it would also say if you're an active grantee. And then it would at least have the _____ in order to _____ things that already have been done, because what we do know is while one works in one community, it might not work in another. So that would be the step that I would actually do, is look at what state you're in and who's specifically awarded [ph] in the past. Ingrid?

Donato: I have three resources that I want to let you know about. First, I'm going to go back to NREPP, the National Registry for Evidence-based Programs and Practices. You're going to enter in the terms that you're interested in, which would be mental health promotion or healthy development, and they're going to be able to pull up the evidence-based programs that will address that. Great resource. In addition, we support two technical assistance centers that have resources around healthy adolescent development. The whole term is National Resource Center for Mental Health Promotion and Youth Violence Prevention. The website is healthysafechildren. I can pop the links on in there. There's going to be a wealth of resources for you.

As well as our Now is the Time Technical Assistance Center. This is a TA center that was launched in response to the Newtown shooting in Connecticut. There are a number of resources and technical assistance available to them, and so I will try to pass on three of those websites for you where you can go for technical

assistance about finding evidence-based programs or resources for engaging—working for healthy kids.

Unti: Great. Thank you all so much.

Wright: This is James. I just wanted to add one last thing. When looking at the TA, again, I go back to SPRC, but they used to operate a best practices registry. And they don't anymore, but it was the step between programs that have been implemented and waiting or trying to get evidence base. So they took that out, but if you look in the resources section there, you'll still find all of them and there are quite a few. But I was thinking more along the lines originally of answering actual presentations. There may not be as many of those, but it'll at least link up to the programs.

Unti: I just want to let everybody know that there's questions about the resources that are being shared. Yes, we will be summarizing the questions and answers and list of resources that are shared and getting those back out to everybody. So I'm going to look for—see if there's some more questions here from the participants. I see several people typing in an app or a website See Something, Say Something today. I don't know James, Ingrid or Tom, if you're familiar with that or you can say something about that.

Donato: This is a campaign and I don't want to respond because I'm not 100% sure. I think there's a couple of them that are out there. The See Something, Say Something is coming out of Homeland Security, so it might be something a little different that you're looking for, but that's what I'm tracking on. But I would love to hear some more.

Unti: I'm not familiar exactly with that but again, people are just typing in these other—

Donato: I'm going to be looking it up so I love people passing on wonderful resources.

Unti: It's an app created by kids and it sounds like it might be a bullying prevention app but I'm not exactly sure. I'm waiting for more text to come in. Being mindful of our time, we do still have time for more questions, so let's see. There's a question, thank you, this has been very helpful. Do we have permission to use the slides and information as we work with schools? I think that might be a FSBY question, I'm not sure. I don't know if Labrita wants to answer that now or we can send information out when we send the summary of information out to everybody.

White: Hi, this is Labrita. Yes, we definitely want you to utilize these resources, to share them with your partners. What we typically do is make, and Carrie [ph] you can chime in if I'm missing a step in the process. But typically we post and make all of our presentations available to you, so definitely we encourage you to share the information. We'll make it available as soon as possible. And I'm saying as soon as possible because I'm not absolutely certain of the exact timeline. But if you do not receive an email or an eblast from the prepTNTA email address announcing the availability of the slides and the information, please reach out to your individual project officer and they should be able to get back with you within a day or two to let you know when the resource will be available. Okay? Thank you.

Unti: Thanks, Labrita.

F: I'll put the link where the webinar archive will be online so you will have that as well, but yes, we will send out the slides and it will be archived online.

Unti: Okay, great. Any other questions? I'm looking in our chat box. Somebody noted See Something, Say Something has to do with sexual abuse assault. Thank you for the clarification. One person has commented and maybe the participants, we still have time for a little bit more conversation, in southern New Mexico, we struggle with children separated from parents. DACA is creating stress and depression among children. Do any of the panelists want to make a comment or respond to that?

Donato: So James and I are federal employees, so our ability to comment may be not as forthcoming. But I agree. We're seeing a lot of struggles with this. For resources, another wonderful resource if you're not experienced with it already is our National Child Traumatic Stress Network and our National Child Traumatic [OVERLAPPING] Network and I can put that link in the website as well.

they're going to have a lot of resources around a whole constellation of issues—traumatic experiences that children can have, including those related to immigration issues and separation related to that, as well as they're going to have resources available for children affected by hurricanes that Texas and Florida and Puerto Rico and many of our areas are experiencing as well. So if you're not familiar with the resource, I'll put it in the chat box and I would strongly encourage you to check that out.

Wright: And I would also want to mention that if it is behavioral health related, SAMHSA does also have a helpline for substance abuse and mental health. And so that is

not the National Suicide Prevention Lifeline, obviously. If the individual is suicidal, we would encourage anyone regardless of race, ethnicity, gender, whatever, to call the National Suicide Prevention Lifeline. But also SAMHSA does have a specific helpline and so those are resources that anyone can use as well.

Unti: Great. Tom, did you have anything to add?

Anderson: Yes, I do.

[TECHNICAL COMMENTS]

Anderson: I'm going to tag on another resource that is not necessarily tribal, although he has been doing it. It's out of Utah. It's called The Hope Squad. Dr. Greg Hudnall has amazing results on a youth suicide prevention program that they've developed. Actually, the state has embraced it and it is in a lot of high schools around the state. He is extending his effort around the country, at least in troubled communities. I would share their website with you and feel free to contact Dr. Hudnall and his group. It's highly innovative and youth-led prevention. So you'll be shocked on the success he's had with that program.

Unti: Thank you very much for those additional resources and insights. So there's a lot of resources again being posted in response to the questions, and as we said, we will be summarizing all of these, the questions and answers with all the resources and we will be sending those out. Those will be available. We do have a little bit of time left, so I'm going to do just another quick look to see if we've addressed all of your questions or if you have additional questions please type them in now.

It looks like we have addressed all of them. I'm going to take the time and then I'll check back and see if there's more questions.

But I do want to just take the time on behalf of all of the panelists and FYSB, thank you so much for your participation today. And again, this webinar and recording will be posted on the exchange as Labrita mentioned. We don't have an exact date but hopefully it will be sooner rather than later. So we'll keep an eye out for that and so all this information will be available for you. I'm also posting the contact information for the presenters. If you have follow-up questions, you can contact the presenters, the panelists.

And before you leave, I'm still going to keep it open for questions, here's references for today's information and I want to please encourage all of you to take a moment to fill out the evaluation for today's webinar. It's always important to get your feedback so that we know how to improve these for the future. I'm going to look at a couple of questions. A question came in, how do we get a cert? I'm not sure—

F: It sounds like that's related to certification for participating in the training. And so if your question is regarding social work or counseling certification points or for the—not just those two but I think there's also CHES [ph] certification, we're not offering it for this specific session. So I do have to apologize if that's what you're requesting.

Unti: Thank you. Are there any other questions? It looks like we're getting to the end of our time. Again, we want to thank everybody for your participation and for all of your great questions. So there's still a couple of questions coming in about

needing something to say that you participated in this webinar, and I'm going to ask you to directly—we will either directly follow up with you or can you directly follow up with your project officer and they can advise you on that question. With that, I think that's it, so I'm going to say everybody have a wonderful day and thank you again everybody, the presenters for your time. I think we will close out the webinar.

[END RECORDING]