hypothesize that younger youth and multiple forms of bullying (i.e., verbal, physical, cyber) increase one's odds of reporting current suicidality.

Methods: We analyzed data collected between June 2013 and February 2018 from 12,001 adolescent patients in an urban, pediatric ED who self-administered the Behavioral Health Screen-Emergency Department (BHS-ED). The BHS-ED is a computerized, self-administered assessment for adolescents in nonpsychiatric medical settings that evaluates depression, suicide, post-traumatic stress, violence, traumatic exposure, bullying, and substance use. BHS-ED screening is standard of care within this ED for all adolescent patients between ages 14 and 18. The sample identified primarily as female (65.1%) and African American (53%). Participants were, on average, 15.66 years old (SD = 1.27). We used multiple logistic regression to estimate the odds and 95% confidence interval (CI) of current suicidality associated with age and number of bullying incidences (verbal, physical, and/or cyber) after controlling for gender and depression—factors considered to be robust predictors for adolescent suicide and bullying.

Results: Twenty-eight percent (n = 3, 458) of participants reported being verbally, physically, or cyber bullied one or more times in their lifetime. Twenty-six percent (n = 3,129) of adolescents reported being verbally bullied, 7.5% (n = 899) reported being physically bullied, and 7.6% (n = 908) reported experiencing cyber bullying. Fifteen percent (n = 1,765) of adolescents reported a history of suicidality compared to 6.5% (n = 775) who reported current suicidality. Controlling for gender and depression, younger age (OR = 0.79, 95% CI=0.74-0.85) and more types of bullying increased the odds of reporting current suicidality (OR = 1.21; 95% CI=1.10-1.33).

Conclusions: Study findings suggest that younger age and experiencing multiple types of bullying (i.e., verbal, physical, and cyber) may serve as important clinical indicators of possible suicidality in adolescent patients presenting to EDs. It is important that emergency clinicians hold an awareness of the association between bullying and suicidality within adolescent patients so that they can promptly respond to such patients with appropriate and effective interventions and referrals.

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YOUTHS AND POOR EMOTIONAL WELL-BEING, IS IT JUST A MATTER OF STRESS?

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Purpose: The aim of our study was to assess factors influencing emotional well-being among youths over a two-year period.

Methods: Data were obtained from the T1 and T3 waves of the GenerationFRee study during the 2015-16 and 2017-18 school years. Students aged 15 to 24 years in post-mandatory education were invited to participate in a web-based self-administered anonymous questionnaire aiming to assess their lifestyles. Using the WHO-Five Well-Being Index with a result < 13/25 indicating a poor emotional well-being (WB), the sample (N=1311) was divided into four groups according to the evolution of their WB: (1) good at T1 and T3 (GT1T3 : 67.94%), (2) good at T1 and poor at T3 (GT1PT3 : 13.21%), (3) poor at T1 and good at T3 (PT1GT3 : 8.44%), (4) poor at T1 and T3 (PT1T3 : 10.41%). Groups were compared on gender, age, chronic condition, academic track, socioeconomic status, family structure, perceived health status, stress level, relationships with their parents, and academic success. Significant (p<0.5) variables at the bivariate level were included in a multinomial regression analysis using GT1T3 as the reference category. Results are given as relative risks ratios (RRR).

Results: At the bivariate level, groups differed in gender, age, family structure, perceived health status, reporting a chronic condition, advanced puberty, socioeconomic status, stress level and relationship with parents. In the multivariate analysis, youths in the GT1PT3 group, compared to GT1T3, were more likely to report a chronic condition (RRR 2.15), more stress at T3 (RRR 1.44) and poor perceived health status at T3 (RRR 5.87). No differences were found at T1. Those in the PT1GT3 group were older (RRR 1.15), had a poorer relationship with their mother at T1 (RRR 0.74) (no difference at T3), and reported stress at T1 (RRR 1.36). Finally, those in the PT1T3 were less likely to report a disrupted family structure (RRR 0.44), but more likely to report a worse relationship with their father at T1 (RRR 0.81), more stress at T1 (RRR 1.34) and T3 (RRR 1.43), as well as poor perceived health status at T1 (RRR 5.84) and T3 (RRR 8.33).

Conclusions: Youths' emotional well-being is complex and can be influenced by multiple factors. Using a longitudinal approach, we have highlighted that the level of stress is considerable, especially among those who continue to report a poor well-being over time. Moreover, stress seems to be independent from gender or academic success. Additionally, reporting a poor health perception is also associated to poorer levels of emotional well-being (at T3). Finally, our results also underline the importance of the relationship with parents. Inquiring about stress could be a good proxy for emotional well-being. This approach could be especially useful among males who usually tend to underestimate their emotional worries.

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PREVALENCE AND EARLY LIFE FACTORS ASSOCIATED WITH RISK BEHAVIORS IN ADOLESCENCE: A POPULATION-BASED COHORT STUDY

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Purpose: Risk behaviors in adolescence affect the health status, well-being and the healthy development of individuals' personality. Understanding the early-life determinants of such risk behaviors is therefore extremely important for prevention. This study evaluates the extent to which maternal behavior during pregnancy, birth outcomes and perinatal health status affect risk behavior in adolescents at age 11.

Methods: A population-based birth cohort (n=4231) in Pelotas, Brazil, was followed-up in several occasions from birth to 11 years. Prevalence of outcomes with their respective confident intervals were described. Logistic regression was used to study the associations between early variables and risk behavior in adolescents, adjusting for demographic factors.

Results: The prevalence of main variables related to aggressive behavior, physical inactivity, depressive behavior and substance and tobacco experimentation/use was: involvement in fights 14.0%, CI95% 12.9-15.2; involvement in fights with the use of any kind of gun 7.8%,