Mindful Continuing Education

Teen Suicide Prevention and Response

1. You are designing a teen suicide prevention initiative for a large U.S. city. Based on recent epidemiologic data described in the course, which population trend should most strongly shape your prioritization of outreach efforts?

A. Prioritize outreach to Black youth, whose suicide rates in the 10–24 age range have shown the largest percentage increase in recent years.
B. Focus primarily on White youth, because they currently account for the majority of all suicides across the lifespan.
C. Concentrate on Hispanic youth, because they have the highest rates of attempted suicide of any racial or ethnic group.
D. Direct resources away from racial disparities and toward general anxiety screening, because adolescent suicide rates have been decreasing overall since 2007.

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2. A pediatrician tells you they avoid asking teens directly about suicide because they fear it will "put the idea in their head." According to the course content, how should you respond?

A. Agree that suicide should not be mentioned unless a teen has already disclosed a specific plan, to avoid reinforcing suicidal thinking.
B. Acknowledge the concern and suggest using vague questions about stress rather than mentioning suicide explicitly.
C. Recommend screening only for depression symptoms, since most suicidal teens will volunteer suicidal thoughts without being asked.
D. Explain that research shows open, direct conversations about suicide can reduce suicidal ideation and do not increase the likelihood of a suicide attempt.

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3. A 15-year-old who was recently cyberbullied begins giving away prized possessions and suddenly appears cheerful after weeks of depressed mood. How should these changes be interpreted using the warning sign and risk framework from the course?

A. As acute warning signs of suicide (giving away belongings, sudden happiness after depression) emerging in the context of a significant stressor, indicating elevated risk.
B. As protective factors, because cheerfulness and sharing possessions suggest improved coping and connectedness.
C. As long-standing risk factors, because they indicate a chronic pattern of social isolation unrelated to recent events.
D. As neutral behaviors that are expected adolescent experimentation and not associated with suicide risk in the absence of substance use.

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4. A 16-year-old with depression, prior bullying, access to unsecured prescription medications at home, and a strong bond with a younger sibling presents to clinic. Using the risk and protective factor framework in the course, what is the most accurate formulation of their suicide risk profile?

A. Because they recognize bullying as a problem, this awareness functions as a protective factor that outweighs environmental risks such as unsecured medications.
B. Their bond with a sibling fully negates the elevated risk conferred by depression and bullying, so they are at minimal risk.
C. Suicide risk is driven almost entirely by family history and generational trauma, so current stressors and access to medications are less relevant.
D. They have multiple converging risk factors (mental health condition, stressful life events, easy access to lethal means) that are partially offset by at least one key protective factor (responsibility to a loved one).

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5. A primary care practice wants to align with the American Academy of Pediatrics (AAP) recommendations for suicide risk screening in adolescents. Which protocol best reflects the guidance described in the course?

A. Use a general depression questionnaire without suicide questions, because most youth at risk for suicide will meet criteria for depression.
B. Screen only those adolescents aged 12 and older who present with behavioral complaints, because targeted screening is more efficient.
C. Implement universal suicide risk screening with a clinically validated tool for all patients aged 12 and older, in addition to but not limited to depression screening.
D. Limit screening to youth with a documented history of suicide attempts, since universal screening may pathologize typical adolescent distress.

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6. A 14-year-old screens positive on the Ask Suicide-Screening Questions (ASQ). According to the brief suicide safety assessment approach in the course, what is the most appropriate next step?

A. Complete the assessment solely with the parent present to avoid distressing the adolescent by discussing suicide.
B. Immediately notify the parents and arrange for emergency hospitalization without further assessment of the adolescent’s thoughts or intent.
C. Repeat the same screening tool at the same visit to confirm the result before discussing suicide directly with the adolescent.
D. Conduct a confidential, one-on-one suicide safety assessment that explores suicidal thoughts, plans, behaviors, intent, and supports using a trauma-informed, non-judgmental approach.

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7. While creating a safety plan with a 17-year-old and their caregiver, which element is essential to include to align with the evidence-based, collaborative safety planning model described in the course?

A. The teen's own identification of personal warning signs, coping strategies, supportive contacts, emergency resources, and steps to reduce access to lethal means.
B. A clinician-written list of generic coping tips that is the same for all patients, regardless of culture, language, or developmental level.
C. A statement by the teen promising not to harm themself, without detailing specific strategies or environmental safety changes.
D. A focus on educating the caregiver about depression while deferring discussion of lethal means and coping strategies to later sessions.

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8. During safety planning, a social worker is working with a family that keeps firearms and several unused prescription medications at home. Which approach best reflects trauma-informed safety planning and lethal means counseling as outlined in the course?

A. Explain that medication safety is more important than firearm safety, because most youth suicides involve overdoses rather than guns stored at home.
B. Instruct the family that responsible gun ownership is incompatible with safe care of a suicidal teen and insist they permanently discard all firearms.
C. Focus on teaching the teen additional coping skills and avoid bringing up firearms or medications so as not to increase family defensiveness.
D. Use non-judgmental, culturally responsive language to collaborate on practical ways to lock or remove firearms and secure or dispose of medications, emphasizing that these safety steps are standard practice when suicide risk is present.

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9. A 15-year-old reports daily suicidal thoughts, a specific plan to use an unsecured firearm at home that evening, and strong intent to act. Using the clinical pathways framework from the course, which disposition is most appropriate?

A. Classify the youth as high or imminent risk and arrange an emergency mental health evaluation, engaging the emergency department or a mobile crisis/acute evaluation service if no on-site evaluator is available.
B. Classify the youth as moderate risk and schedule a routine outpatient mental health evaluation within several weeks, providing a crisis phone number.
C. Classify the youth as low risk because they disclosed their thoughts, and focus on outpatient psychotherapy and a written safety plan without urgent evaluation.
D. Defer risk stratification and disposition decisions to a later visit after the family has had time to secure the firearm and discuss the situation at home.

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10. A high school student dies by suicide. The district wants to respond thoughtfully. Which strategy best reflects the comprehensive postvention principles in the course?

A. Rely on community mental health clinics to respond if contacted by grieving families, without establishing school-based protocols or outreach.
B. Hold a large memorial assembly with detailed discussion of the method of death to honor the student and allow students to express their grief freely.
C. Instruct staff not to mention the suicide and treat the death as if it were from natural causes to prevent any additional students from thinking about suicide.

D. Activate a coordinated postvention plan that includes rapid, compassionate support for directly affected students and staff, education about suicide risk, proactive outreach to loss survivors, safe media communication, and efforts to reduce suicide contagion.
