Identifying Suicide Risk in Foster Care: Screening Practices and Policy Implications

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Abstract

Youth in foster care are at significantly increased risk for suicide compared to peers not in foster care, necessitating urgent evaluation of systemic barriers, fragmented care coordination, and limited procedures currently in place surrounding suicide screening for these youth. Universal screening, training for both healthcare and child welfare professionals, advocacy for updated policies, and integrated care models that champion care coordination across systems are key to providing early identification and interventions for suicide risk for youth in foster care. Given known disjointed care, medical complexities, and health disparities facing youth in foster care, trauma-informed and collaborative care must be provided by all professionals to mitigate known suicide risk and provide equitable healthcare for youth in foster care.

Keywords: foster care, child maltreatment, suicide, suicidal ideation, LGBTQIA+

With suicide being the second leading cause of death in adolescents, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) in 2021 declared a mental health emergency for adolescents necessitating the need for action from health care professionals and community partners (Hoffman et al., 2022). Yet the risk of suicide among youth in foster care is even higher. All professionals involved in caring for youth in foster care must be trained in the importance of understanding the increased risk of suicide for youth in foster care, but also the need for promoting protective factors, adequate screening, and referral to appropriate resources. The purpose of this article is to examine current suicide screening practices in foster care and the implications for mental health and primary care providers, child welfare systems, and policymakers.

Background and Significance

Over 500,000 youth were served by the foster care system in 2024 (Children's Bureau, 2025). Evidence has clearly demonstrated that youth in foster care have high rates of mental health disorders, with youth transitioning out of care being two to four times more likely to have a mental health diagnosis (Engler et al., 2022, Greiner & Beal, 2017; Havlicek et al., 2013; Lohr & Jones, 2016; McMillen et al., 2005; Tarren-Sweeney, 2008). Their mental health problems include, but are not limited to, post-traumatic stress disorder (PTSD), anxiety, depression, attention deficit hyperactivity disorder (ADHD), and behavioral disorders, such as oppositional defiant disorder, attachment disorder, non-compliance, hyper-vigilance, and dysregulation (Engler et al., 2022, Greiner & Beal, 2017; Havlicek et al., 2013; Lohr & Jones, 2016; McMillen et al., 2005; Tarren-Sweeney, 2008). The American Academy of Pediatrics (2021) has deemed youth in foster care as a population with special and unique needs that require comprehensive health care services.

With the current mental health crisis facing youth today, suicide ranks as the second leading cause of death in adolescents and there is a known increased suicide risk for youth in foster care (Hoffman et al., 2022). Evidence demonstrates that a history of trauma compounded with a lack of consistent social or relational support systems increases the risk of youth suicide (Engler et al., 2022; Okpych & Courtney 2018; Taussig et al., 2014). Factors

that increase suicide risk include a history of child maltreatment, multiple placements, length of time in care, and frequent engagement with the child welfare system (Engler et al., 2022; Okpych & Courtney 2018; Taussig et al., 2014).

Youth in foster care experience suicidal ideation five times more than youth not in foster care and are four times more likely to attempt suicide (Engler et al., 2022; Lohr & Jones, 2016). Furthermore, studies have shown that for youth in foster care, up to 26% self-reported suicidality, 4% had a suicide plan, and 4% had a suicide attempt (Engler et al., 2022; Lohr & Jones, 2016; Taussig et al., 2014). There have been few studies that have examined suicidality among youth in child protective services (CPS). A study by Yi et al. (2020) demonstrated that approximately 33% of children have experienced an investigation for alleged maltreatment, with roughly 8% of youth having a confirmed case of child abuse or neglect. Findings from a large population-based study showed increased rates of suicide among youth and children who have prior reports and contact with CPS (Palmer et al., 2021). Results from these studies confirm the importance of early intervention, access to screening and mental health services, and preventative care (Engler et al., 2022; Lohr & Jones, 2016; Palmer et al., 2021; Taussig et al., 2014; Yi et al., 2020).

Suicide Screening Practices

The AAP recommends screening for suicidal ideation in all children over the age of 12 and those 8–11 years of age when clinically indicated (Hagan et al., 2017). To identify children, youth, and young adults in foster care who are at risk for suicidal ideation or suicide attempts, the use of diagnostic screening tools at regular intervals is necessary. While a thorough clinical interview may identify suicide risk, diagnostic screening tools provide an objective measurement, and evidence suggests that the use of tools and questionnaires are more likely to reflect the youth's feelings and thoughts (Katz et al., 2023). This screening may be performed using an expanded depression tool which includes a comprehensive suicide screening or with a suicide specific screening tool. In addition, several validated depression tools, such as the Patient Health Questionnaire (PHQ) 9, may be utilized as a preliminary screener to identify youth who should complete a tool specific to suicidal ideation and risk (Kroenke et al., 2001; Spitzer et al., 2006).

Suicide screening tools range from brief screening tools like the Ask Suicide-Screening Questions (ASQ) to more in-depth, comprehensive assessments such as the Suicidal Ideal Questionnaire Junior (SIQ-JR), the Columbia Suicide Severity Rating Scale (C-SSRS), the Self-Harm Behavior Questionnaire (SHBQ), and the Suicide Probability Scale (SPS) (Eltz et al., 2007; Gutierrez et al., 2020; Horowitz et al., 2012; Posner et al., 2011; Reynolds & Mazza, 1999). Despite these readily available tools, in a study evaluating the screening and assessment of suicidal teenagers, Katz et al. (2023) found that less than 50% of teenagers and young adults in the foster care system are screened for suicidal ideation, even though over 90% were being seen in a health care setting and screened for their physical health.

A large barrier to universal adoption of suicide screening practices for children and youth in foster care is the lack of a standardized tool and a lack of clarity surrounding who should administer the tool. Brown (2020) presents several options for the implementation of universal screening, each with their own challenges. The first option is to refer all children and youth to mental health professionals for evaluation. This option is not sustainable due to the shortage of mental health professionals and the unduly increased resource utilization and cost within the child welfare system. (Brown, 2020). Another option is to have primary care providers provide mental health screens for all children and youth (Brown, 2020). However, this strategy operates under the assumption that there is a sufficient number of trained primary care providers available to screen these vulnerable youth. Training foster parents to provide screening has also been suggested; however, this process has not been adequately studied to determine its efficacy and feasibility (Brown, 2020).

The final option presented relies on the case manager to conduct the screening (Brown, 2020). While case managers are trained child welfare professionals, they are not trained healthcare professionals. Although case managers can be trained on brief screening tools such as the ASQ or CSSR, there is insufficient time available for training and for screening, given that most case managers carry caseloads that are large (Brown, 2020). These barriers prevent the implementation of universal screening practices for suicidal ideation in children and youth in foster care.

Specialized Populations within the foster care system and suicide risk

Children of color, children of lower socioeconomic status, and youth who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, and/or asexual (LGBTQIA+) are overrepresented among children in foster care. This further highlights the disparities this population experiences (Dettlaff & Boyd, 2021). LGBTQIA+ youth and children of color are also at an elevated risk for suicide attempts in foster care compared to their counterparts not in foster care (The Trevor Project, 2021). According to The Trevor Project (2021), approximately 13% of LGBTQIA+ youth not in foster care attempt suicide, while that number rises to 35% for LGBTQIA+ youth in foster care. Additionally, 16% of LGBTQIA+ youth of color not in foster care attempt suicide, while 38% of LGBTQIA+ youth of color in foster care attempt suicide (The Trevor Project, 2021). This intersectionality between ethnicity and LBGTQIA+ youth thus compounds the risk for these youths. Due to their increased risk for suicidal ideation and suicide attempts while in foster care, efforts to improve mental health screenings, referrals, and treatments should also be tailored to the unique population of youth who identify as LGBTQIA+ and/or youth of color.

Young adults who age out of foster care are also statistically more likely to die by suicide than their counterparts who are not in the foster care system (Katz 2024; Berlin et al., 2011). Increased rates of other mental health diagnoses and substance abuse also impact this population (Hamilton et al., 2015; Shook et al., 2013). In a study by Berlin et al. (2011), young adults who had aged out of the foster care system had a seven-fold increase in suicide attempts, as compared to youth not in care. Courtney et al.'s (2014) study of youth aging out found that 40.9% had a report of suicidal ideation and up to 24% reported a suicide attempt by age 17. By comparison, 12% of youth not in foster care reported suicidal ideation, and 2.5% reported a suicide attempt (Katz et at., 2024). These alarming statistics indicate that policies and processes must be in place to protect the mental health and well-being of young adults aging out of foster care.

Systemic and Ethical Considerations

Consent and Confidentiality

Although screening practices are needed to identify youth in foster care at risk for suicidal ideation and attempts, the process for screening lacks standardization (Ayer et al., 2020). In addition, interventions are lacking for suicide prevention for youth in foster care (Russell et al., 2021). Youth in foster care often have multiple parties involved in decision-making, such as caregivers of origin, foster caregivers, and social workers (Chateauneuf et al., 2021). Individuals with legal medical decision-making abilities, including mental health care decision-making abilities, may differ between cases and through time as guardianship and permanency plans change for youth in foster care (Chateauneuf et al., 2021; Delgado et al., 2023). Mental health care may be disjointed, records may be inconsistent, and communication and consent may be confusing, not always well documented, or understood (Greiner et al., 2015). The complexity of these relationships; changes in schools, mental health providers, permanency plans; and confusion regarding consent lead to disruptions in care. This may, in turn, cause fragmentation in suicide screening and intervention services.

As the identification of children with suicidal ideation may require the introduction of safety plans,

it will be imperative for ensuring safety to note who the child will be spending time with and where they will be spending time (Delgado et al, 2023). Many youths in foster care have a history of trauma and removal of autonomous decision-making; therefore, youth must be involved in choices surrounding their mental health care and safety planning to provide trauma-informed care (Delgado et al., 2023; Grimmond et al., 2019; Horowitz et al., 2020).

Mandatory Reporting and Liability

The term mandatory reporting refers to the legal and moral obligation of health care providers to report suspicion of child maltreatment. In addition to reporting abuse, healthcare providers caring for children have an obligation to report to prevent self-harm in children (Grossman et al., 2023; Wilson & Lee, 2021). When youth in foster care are identified as having active suicidal ideation, proper measures must occur to ensure the child's safety, including reports to CPS as well as appropriate mental health referrals and evaluations. Barriers to mandatory reporting exist within the foster care system, including uncertainty of who to involve in the report (Wilson & Lee, 2021). Lack of knowledge surrounding how and when to report may result in additional danger to the child. Differences exist within and between states, causing additional confusion (Grossman et al., 2023; Wilson & Lee, 2021).

Cultural and Developmental Sensitivity

Awareness of the youth's culture and developmental stage is essential to support connectedness and communication, as cultural norms and developmental stages often dictate the level of interaction and the language used during conversation (Horowitz et al., 2020). As youth in foster care may have multiple contributing factors making them susceptible to suicidal ideation, an individualized approach consistent with the child's development and culture is necessary. This will promote openness and resilience by helping the child to understand their strengths and ability to problem-solve (Brown, 2020; Chaiyachati et al., 2020; Horowitz et al., 2020). As there is evidence that spirituality, religion, and social supports are protective against suicide, encouraging youth to find communities that provide these may also increase their safety (Horowitz et al., 2020).

Proper identification of cultural history and provision of culturally sensitive care are needed, as certain cultures stigmatize mental health needs and seeking help for them (Centers for Disease Control and Prevention [CDC], 2024). In addition, community-specific cultural factors such as lack of access to health care, the presence of community violence, historical trauma, and discrimination may be associated with an increased risk for suicidal ideation (CDC, 2024).

Implications for Practice

Suicide Risk Training

Caring for the mental health needs of youth in foster care can be challenging due to their trauma histories, the lack of continuity in their health care, and complex social histories (Bowden et al., 2022; Beal et al., 2022; Jones et al., 2020; Szilagyi et al., 2015; American Academy of Pediatrics [AAP] Task Force on Health Care for Children in Foster Care, 2005). Many professionals within multiple agencies can be involved with a youth in foster care at various touchpoints in their foster care journey, creating the need for a coordinated and collaborative effort from all professionals. As discussed, professionals involved in caring for these youth can include child welfare workers, healthcare providers, foster caregivers, educators, court-appointed special advocates (CASA), guardians ad litem, and professionals in community partner organizations, such as non-profits, faith-based organizations, civic groups, educational institutions, and legal and judicial systems. Barriers, as well as pros and cons, have been discussed regarding various professionals providing screening for suicide risk for youth in foster care. Child welfare professionals are charged with meeting the many needs of youth in foster care. With basic needs, such as housing, food, clothing, and education

at the forefront for child welfare professionals, often mental health needs and screening for suicide risk are not a priority (Brown, 2020). Foster caregivers are also often ill-equipped to adequately assess suicide ideation; in addition, a caregiver-child dynamic often complicates an already tender social situation (Brown, 2020). Nevertheless, child welfare professionals and foster caregivers should be trained on the increased risk of suicide among children in foster care, the warning signs to monitor, and the need for referral for primary care and mental health services. All children and adolescents in foster care should be referred to a primary care provider for a well-child visit, mental health assessment, and ongoing surveillance and follow-up (Beal et al., 2022; Szilagyi et al., 2015).

Interprofessional Collaboration

Given the known mental health crisis facing adolescents, access to mental health services can be limited, especially for youth in foster care who have placement instability and see various health care providers during their foster care journey (Halasz et al., 2025b). Often, youth in foster care have a complex social system with many professionals within varying agencies working in silos. This can create chaos, duplications of services, and added stress for these youth. Integrated care models involving all professional touchpoints are needed to provide optimal and equitable health outcomes.

Primary care providers play a key role in providing access to care and screening for mental health problems and suicide risk (Hoffman et al., 2022). The AAP recommends all youth in foster care be established with a primary care provider in a medical home model (AAP Task Force on Health Care for Children in Foster Care, 2005). The AAP also recommends that all primary care providers screen adolescents, twelve years and older, and other age groups as clinically appropriate for suicide risk and protective factors (Hua et al., 2024). Primary prevention for suicide risk in adolescents begins with promoting resilience, relational care through building relationships with family and peers, and addressing any parental mental health influences (Horowitz et al., 2020). Secondary prevention for suicide risk involves understanding and recognizing warning signs for suicidal ideation, screening for suicide crisis, safety counseling, and appropriate referral for evidence-based treatments (Horowitz et al., 2020).

Primary care models with integrated behavioral health can be extremely helpful in providing access to care for youth, especially those in foster care (Hoffman et al., 2022). School-based health models (including those using telehealth methods) can also be beneficial in addressing the mental health needs of youth in foster care (Hoffman et al., 2022). Youth in foster care often have unpredictability with foster placements, multiple appointments (including physical and mental health visits), visitation, and court hearings (Martin et al., 2023). The utilization of school-based mental health visits and telehealth visits have been shown to be promising for youth in foster care and could be advantageous in eliminating missed educational instruction and beneficial for providing opportunities for suicide risk screening despite placement changes (Halasz et al., 2025a; Greiner et al., 2023; Fortin et al., 2023; Martin et al., 2023; Hoffman et al., 2022).

Trauma-Informed Approach

A key component in caring for the mental health needs of all children, but especially youth in foster care, is trauma-informed care or relational healthcare. Trauma-informed care is focused on providing safe, stable, nurturing relationships (Forkey et al., 2021; Duffee et al., 2021). In trauma-informed care, professionals who interface with youth in foster care understand the effects of adverse childhood experiences (ACEs), the need to monitor trauma symptoms, and the reality that ACEs can increase a youth in foster care's suicidal risk (Brown, 2020). Positive relationships in any context help youth in foster care develop the skills needed to promote self-efficacy and growth, empowerment in decision making, and a strengths-based approach to building resiliency (Forkey et al., 2021; Duffee et al., 2021). Protective factors, including individual, family, and community resources, help support positive

relationships and diminish the negative impacts of trauma and promote resilience (Goddard et al., 2022). This may include reduced access to harm-inflicting items such as weapons and medications, open communication between trusted adults and youth, connectedness, academic achievement and support, and increased physical activity (Brown, 2020; CDC, 2024; Horowitz et al., 2020). Communication and models of integrated care among interprofessional partners involved with the child welfare system are necessary to prevent duplication of services, provide suicide assessment and screening at various key encounters in the youth's foster care journey, and coordinate plans of care (Quick & Halasz, 2025).

The AAP, through *Fostering Health,* has guidelines for increased surveillance for youth in foster care by primary care providers (AAP Task Force on Health Care for Children in Foster Care, 2005). Screening and understanding the impact of ACEs should be followed by a trauma-informed approach. While suicide risk screening is recommended yearly for all youth, screening in a range of specific situations could be an opportunity for better surveillance for youth in foster care. Such situations might include changes to permanency plans, multiple changes to placements and schools, and lack of contact with family members and siblings. The AAP recommends a multi-part assessment when youth enter foster care: an initial health screening within 72 hours of placement, followed by a more comprehensive health assessment within 30 days of placement, and routine follow-up with well checks every six months after the age of two. Assessments are also recommended during child maltreatment investigations, placement changes, and discharge from foster care (Szilagyi et al., 2015). Training child welfare professionals and foster caregivers to monitor and screen for suicidal ideation, alongside enhanced health surveillance, helps supplement pediatric-focused health care providers conducting trauma-informed suicide screenings during routine visits, particularly during periods of elevated stress among youth in care.

Policy and System Level Implications

Legislation and Funding

Caring for the mental health needs of youth in foster care to decrease suicide risk requires funding and legislation to protect this vulnerable population. Almost all children in foster care are eligible for Medicaid, which ensures access to healthcare services (Beal et al., 2022). The federal government provides overarching legislation and funding for youth in foster care; however, state and local agencies oversee care and set rules for youth in foster care, creating variability across the nation (Beal et al., 2022).

The Affordable Health Care Act increased Medicaid access for youth aging out of foster care by providing coverage up to twenty-six years of age (Bullinger & Meinhofer, 2021). The age at which youth age out of care varies by state from age 18 to age 23. This increase in coverage allows aging out youth to continue to receive comprehensive physical and mental health care (Bullinger & Meinhofer, 2021).

The Family First Prevention Services Act in 2018 provided a two-part child welfare reform. First, financial support was increased specific to family preservation, including increased support for training, community-based mental health services and family support. Secondly, financial limitations were placed on congregate care (Lindell et al., 2020). This legislation is important in assessing and preventing suicide ideation in youth in foster care, as prevention begins prior to youth entering foster care, focusing on families with high risk for child maltreatment and neglect and known mental health problems (Lindell et al., 2020).

While efforts to improve Medicaid funding and legislation have been made for youth in foster care at the federal level, further efforts are needed at both the state and federal levels, given the known poor mental health outcomes facing these youth and increased suicide risk. Medicaid funding could be in jeopardy under current legislation, H.R. 1 - One Big Beautiful

Bill Act (Public Law 119-45) that took effect July 4, 2025. This could pose threats to funding for youth in foster care, as Medicaid cuts in the bill threaten their primary source of healthcare support (One Big Beautiful Bill Act, 2025; Beal et al., 2022; Mann et al., 2025). Overall expansion of Medicaid coverage for these youth and uniformity across states regarding foster care guidelines and physical and mental health coverage is crucial to provide needed screening for early identification of suicidality in youth in foster care and treatment for those at risk.

Data Collection and Evaluation

Further data is needed to evaluate gaps in practice and standardization in suicide screening for youth in foster care (Brown, 2020). The Adoptions and Foster Care Analysis and Reporting System (AFCARS) is the data collection and analysis system used to track and report data for youth in foster care (Children's Bureau, 2025). AFCARS's data collection focuses primarily on demographic data for youth in foster care, including age, gender, race, reason for care, length and type of placement, and permanency (Children's Bureau, 2025). There is also a National Youth in Transition Database (NYTB) that collects demographic data for youth in foster care and also looks at such outcomes as high school graduation, employment, incarceration, and pregnancy (Children's Bureau, 2023). The third child welfare data collection system available is the National Child Abuse and Neglect Data System (NCANDS), which collates data from all 50 states, the District of Columbia, and Puerto Rico, to produce a national data set on reported child abuse and neglect (Children's Bureau, 2024).

Currently, there is no uniform data collection around suicide screening, mental health service utilization, and mental health outcomes for youth in foster care. Given the high rates of mental health problems and suicide for youth in foster care, expanding current data reporting systems to include surveillance around suicide screening, mental health utilization, and health outcomes for youth in foster care is imperative.

Policy and Reform

Policies should be directed to ensuring adequate education and training on suicide screening for all child welfare and health care professionals serving youth in foster care. This is crucial to ensure that said youth are appropriately identified and referred for evidence-based treatments. While screening should be a priority, other resources also need to be in place during times of crisis, including safe, stable housing and nurturing relationships, providing a sense of belonging. Unfortunately, some youth in foster care have added stress because of placement instability and insecurity, court proceedings, visitation, change in child welfare personnel, disruption in education, and transition out of foster care (Szilagyi et al., 2015).

Policy focus should also be directed at securing adequate crisis support and 24/7 hotlines, especially for high-risk populations within the foster care system, such as youth aging out of foster care and LGBTQIA+ youth. Recently funding was removed for the LGBTQIA+ population suicide prevention hotline (Shastri, 2025). Given that there is a considerable population of LGBTQIA+ in foster care and this population has a higher suicide risk, loss of resources could be detrimental for this sub-population of youth in foster care (Cruce, 2024). Present-day threats to Medicaid funding could also be detrimental for these youth. These threats underline the need for policies ensuring that all youth in foster care have appropriate healthcare coverage and access to health maintenance and crisis services to reduce suicide risk.

Conclusion

Youth in foster care are at an increased risk for suicidal ideation and attempts compared to their peers who are not in foster care. Inadequate screening policies and standardization undermine early identification of children in foster care with thoughts about self-harm. This situation perpetuates the elevated risk of suicide for these youth. Although a history of trauma and lack of permanency may predispose youth in foster care to suicidal ideation, implementation of proper screenings and mental health interventions may prevent suicide of these youth. To provide holistic care to these vulnerable children and young adults, multiple disciplines need to collaborate to change policies, procedures, legislation, and clinical guidelines.

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