The Urgent Need to Recognize and Reduce Risk of Suicide for Children in the Welfare System

Lisa M. Horowitz, PhD, MPH,[a] Geoffrey Kahn, MSPH,[b] Holly C. Wilcox, PhD[c]

Youth suicide is a global public health crisis. The National Action Alliance for Suicide Prevention and the National Institute of Mental Health aim to reduce the suicide rate 20% by 2025.[1] To reach this goal, it will be important to implement universal policies and programs and tailor suicide prevention strategies to ensure mental health professionals are meeting the needs of groups at highest risk. In this issue of *Pediatrics*, Ruch et al[2] present data on an understudied, high-risk population of abused and neglected youth. This is the first study in which authors characterize youth in the child welfare system (CWS) who die by suicide and compare them with living CWS controls. These results have potential to inform proactive and integrated approaches to suicide prevention in the CWS, a boundaried setting that serves youth at 3.5-fold higher risk for suicide than the general youth population.[3] There is minimal suicide research on youth served in the CWS, a "protected" population, hindering our ability to identify the unique needs and opportunities for suicide prevention in this population.

The Ruch et al[2] study was a retrospective matched case-control design that included 120 suicide decedents aged 5 to 21 years who had an open case in Ohio's Statewide Automated Child Welfare Information System between 2010 and 2017, as well as 1200 CWS controls matched on demographics and year the case opened. The 2 main findings were that suicide decedents in the CWS were more likely to have experienced out-of-home placement and to be diagnosed with mental and chronic physical health conditions compared with controls. Of the suicide decedents, 59.2% had at least 1 diagnosable mental health condition compared with 31.2% of controls. Consequently, they were more likely to present in health care settings in the months before their suicide. Ruch et al[2] found that 90% and 48% of decedents had contact with a health care provider within 6 months and 1 month, respectively of dying by suicide, a rate slightly higher than the general youth population.[4] Most visits were in outpatient settings, although suicide decedents were also 2.57 and 2.63 times, respectively, as likely to visit an emergency department (ED) in the 6 months and 1 month before their death. These findings suggest that CWS-involved youth, especially those in the foster care system, may benefit from suicide prevention strategies embedded into routine medical and mental health care such as suicide risk screening, evidence-based risk assessment, safety planning, and follow-up contacts postdischarge from ED and inpatient care.

Many youth from CWS present with medical complaints; if someone does not ask them directly, "Are you thinking of killing yourself?" they might not bring it up voluntarily.[5] In addition, better care coordination between the health care system and CWS, as well as enhanced follow-up monitoring and

[a]*Intramural Research Program, National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland; and* [b]*Bloomberg School of Public Health and* [c]*School of Medicine, Johns Hopkins University, Baltimore, Maryland*

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Address correspondence to Lisa M. Horowitz, PhD, MPH, Intramural Research Program, National Institute of Mental Health, National Institutes of Health, 10 CRC, Room 6-5362, 10 Center Dr, Bethesda, MD 20892-1276. E-mail: horowitzl@mail.nih.gov

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support could be beneficial for at least the first 6 months after discharge from an ED or psychiatric inpatient unit. Predictive modeling of Medicaid health record data could allow for identifying high-risk individuals for enhanced supports, proactive outreach, and care coordination by the health care system and the CWS, as is done routinely in the Veterans Healthcare System.[6]

There is no one-size-fits-all approach to suicide prevention. We need universal suicide risk detection as well as targeted outreach and enhancements tailored to specific needs of high-risk populations in service sectors such as the CWS. Evidence-based risk assessments should become an integral part of any intake evaluation and any out-of-home placement. CWS staff should be trained in suicide risk assessment,[7] safety planning,[8] and lethal means safety counseling.[9] Young people served by the CWS could be equipped with skills to recognize their own warning signs of suicide risk and coping strategies for managing suicidal thinking. Each child should be given resources like the National Suicide Prevention Lifeline and the Crisis Text Line; they should each be able to identify a trusted adult they can turn to in times of great need. The evidence revealing that out-of-home placements increased the likelihood of death by suicide requires further investigation because it may be a proxy for severity of abuse and neglect, which are strong risk factors for suicide.[10] In studies using a nationally representative sample of youth in the CWS, researchers have not found out-of-home placement to be associated with nonfatal suicide attempts.[11,12] The possible impact of family preservation programs on suicide warrants further study.

Ruch et al[2] should be commended for drawing our attention to suicide risk in children who have been abused and neglected. Allowing those children to pass through the health care system with suicide risk undetected is irresponsible. Implementing universal suicide risk screening[13] in EDs,[14] inpatient medical and surgical units,[14,15] and outpatient health care settings[16] could be an important step in preventing suicide. Given that high-risk youth frequently present to medical settings, we as health care providers have not only an opportunity but a responsibility to implement effective suicide prevention strategies and be the bridge to lifesaving interventions.

ABBREVIATIONS

CWS: child welfare system
ED: emergency department

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