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Sector Insights paper

In this month's insights paper

QUEENSLAND
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The voice of Aboriginal children in out-of-home care: An inter-jurisdictional policy analysis

CHILD SAFETY   OVER-REPRESENTATION

The authors conducted a policy analysis comparing NSW and Victoria out-of-home care (OOHC) legislation and policies to assess how well they support Aboriginal child and youth participation. Using a comparative policy analysis approach, they systematically reviewed OOHC legislation, policy documents and practice frameworks from multiple jurisdictions. The analysis finds a consistent gap between policy intent and practice reality, with participation largely optional and dependent on individual practitioners.

Comparative Table: Aboriginal children's voice in OOHC (NSW and Victoria)

Theme	NSW	VIC
Participation wording in legislation	Explicit requirement (*Children and Young Persons Act 1998*) that Aboriginal care plans be developed in consultation with the child **"to the greatest extent practicable."** This creates flexibility but also potential loopholes.	Similar to NSW, Victoria's *Children, Youth and Families Act 2005* requires providers to create opportunities for children to participate and gives weight to their views **"as far as practicable".** This shifts accountability away from governments and by placing the focus on the individuals.
Legislative framing of participation	NSW legislation recognises participation in Sections 9–10 and embeds "active efforts" requiring practice in partnership with children.	Victoria's legislation (Sections 11–12) requires providers to **encourage and provide adequate opportunity** for participation and convene meetings that include the child for major decisions.
Policy availability and depth	NSW only publicly publishes high-level case management policies (e.g., Permanency Case Management Policy), with much of this focus coming from the Aboriginal Family-Led Decision Making model.	Victoria provides extensive, detailed guidance through the online **Child Protection Manual**, containing procedures and "advice documents" that translate policy into practice.
Participation in practice	Primarily within **care planning**, with no guidance given to support the participation of children and young people for ongoing voice during day-to-day decisions.	Victoria's policies emphasise planning events such as care team meetings and contact arrangements. The available tools support gathering the child's voice through meeting templates and child-friendly resources.
Cultural safety and Aboriginal-specific participation	Family-led decision-making dominates, and **children's voices are often merged into "family voice"**, diluting individual children's views. The Aboriginal Case Management Policy emphasises culturally safe casework and states that Aboriginal children's views must be taken seriously but has **no mechanism those views into action.**	Victoria has Aboriginal-specific guidance (Aboriginal Child Specialist Advice and Support Service; cultural plans; Responding to Aboriginal Children) that include sections on gathering child voice, but again **no monitoring mechanisms**.
Accountability mechanism	**None.** There is no explicit requirement to show how the child's voice influenced decisions. **There are no monitoring or reporting structures.** Relies on worker discretion.	**None.** Victoria also lacks systems to verify implementation, leaving a high level of discretion to individual workers.

Summary

Across both NSW and Vic, the policy language recognises participation, but none of the systems create enforceable, monitored, or culturally grounded mechanisms that ensure Aboriginal children's voices are heard, respected and used in decision-making. Australian governments need to embed Aboriginal children and across all levels of the system through clear policies and practical guidelines that spell out what is expected of every professional in gathering, acting on, and being accountable for children's views in care decisions.

Burns, M., Grace, M., & Avery, S. (2025). *Building a culture of voice and agency for Aboriginal children in out-of-home care: A policy analysis of NSW and Victorian systems.* Australian Journal of Social Issues, Advance online publication. https://doi.org/10.1002/ajs4.70081

The links between childhood sexual abuse victimisation and adolescent offending

YOUTH JUSTICE   CHILD SEXUAL ABUSE

The Australian Institute of Criminology studied 7,800 young people in the Queensland's Youth Justice system, and 377 young males who received specialist treatment through the Griffith Youth Forensic Service (GYFS), The study looked at how childhood sexual abuse (CSA) victimisation shapes later offending. The findings provide strong evidence for trauma-informed, early intervention responses for children and young people with multiple adversities.

Key findings

CSA is highly prevalent among justice-involved young people:
- 8 per cent of Youth Justice clients had CSA histories. This was significantly higher for females at 18.7 per cent compared to only 5 per cent of males (noting the reduced likelihood and increased delay of males disclosing CSA).

CSA victims experience extreme cumulative adversity:
- 93.9 per cent had at least one other form of maltreatment types (emotional abuse, physical abuse, neglect)
- 42.3 per cent experienced **all 4** maltreatment types
- High levels of residential instability, family conflict, sexualised environments and caregiver inconsistency.

Developmental vulnerabilities compound risk:
- Early sexualised behaviour, social isolation, bullying involvement, and placement in out-of-home care were common among CSA-victimised youth.

Gender-specific links between CSA victimisation and sexual offending

For youth with CSA histories, gender-based differences in their most serious conviction were pronounced.

- *Sexual harm:* 27 per cent of males with CSA history were convicted of sexual offences, compared to 1.8 per cent of females. After controlling for gender, young people with CSA histories were found to be over 5 times more likely to be convicted of sexual crimes than violent or non-violent crimes.

- *Violent harm:* 71.9 per cent of females with CSA histories were convicted of violent offences, compared to 47 per cent of males.

The link between CSA victimisation to subsequent perpetration was found to be concentrated to males. The findings suggest a need for a gendered approach with appropriate and timely intervention.

Prevalence of most serious type of conviction of young people who experienced CSA
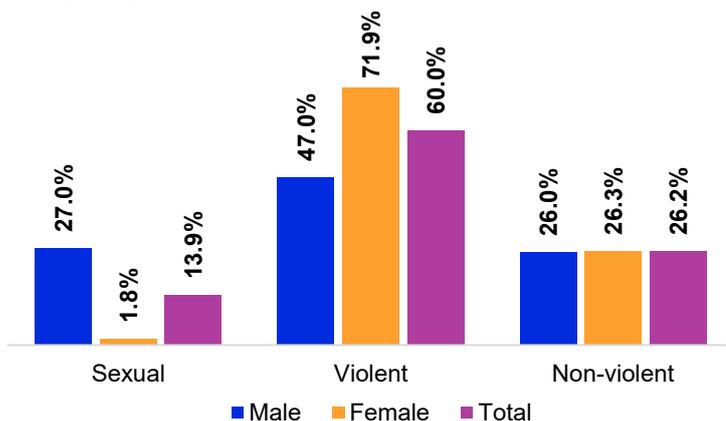

Differences in developmental risk factors between CSA and non-CSA histories

An analysis of the GYFS cohort, comprised of high-risk young people receiving treatment for sexual offending, illustrated significant developmental adversity.

Young people with a history of CSA victimisation were found to have a statistically significant higher prevalence of a number of risk factors compared to young people without CSA histories.

Family characteristics of young people with and without CSA victimisation histories in the GYFS cohort
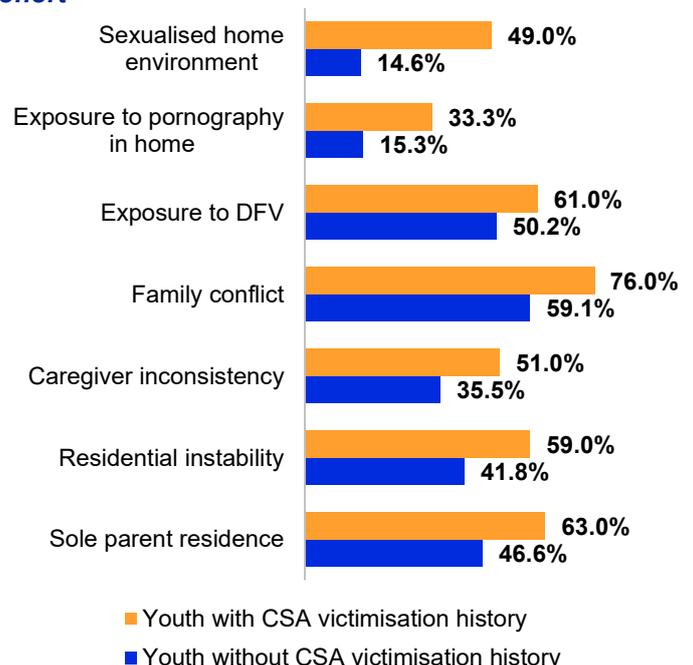
Thomsen, L., Thompson, C., Robertson, A., Bodker, A., Adams, Y., Rynne, J., & Ogilvie, J. (2025). The links between childhood sexual abuse victimisation and adolescent offending. Trends & issues in crime and criminal justice, (721). Australian Institute of Criminology. https://doi.org/10.52922/ti78007

A National Approach to Safety and Quality in Australian Youth Justice: Lessons from healthcare

YOUTH JUSTICE

An article published in the Australian Journal of Social Issues examined why safety and quality in youth justice (YJ) services across the country remain inconsistent and ineffective, despite decades of inquiries, Royal Commissions, and over 3,000 reform recommendations. The authors compared current youth justice approaches with more mature, nationally coordinated safety and quality systems in healthcare to identify lessons for reform and opportunities for a national governance model.

The article compared the 2 systems using different 'dimensions', outlining the current approaches for each system, and suggested potential lessons from healthcare systems that could be implemented to improve youth justice systems across the country.

Dimension	Current Youth Justice System	Healthcare safety and Quality System	Lessons for youth justice
System governance	Fragmented, reactive, and jurisdiction-specific oversight	National, coordinated governance (e.g. Australian Commission on Safety and Quality in health care)	National YJ Safety & Quality governance body with clear national leadership
Standards	Aspirational, non-prescriptive Australasian Youth Justice Administrators (AYJA) standards	Operationalised national standards with clear requirements	Enforceable, measurable, operationalised YJ standards tied to assessment
Oversight and Accountability	Reactive inquiries, coroners, inspectorates; limited enforcement	Regular accreditation cycles with external auditing and action plans	Independent audits with compliance requirements
Performance measurement	Administrative indicators (Productivity Commission reporting), not linked to outcomes on safety or service effectiveness	outcome-focused indicators that measure safety, quality, and patient outcomes.	Nationally consistent indicators meaningfully measure safety, service quality and child outcomes.
Implementation capability	Repeated inquiry recommendations remain unimplemented	Implementation science and continuous improvement framework embedded	System-level support for implementation and improvement science
Workforce culture	Compliance-driven, risk-averse and blame-oriented	"Just culture" that supports reporting, learning and psychological safety	'Safety II' approach – learning-oriented culture with safe frontline practice environments
Approach to safety	'Safety I': focus on failures, compliance and punitive response	'Safety II': proactive learning from successful practice and system behaviour	Shift to 'Safety II' model: systems that learn from "what goes right" and adapt accordingly
Learning system	Limited real-time learning; lessons arise mainly after crises	Incident review system, root-cause analysis and cross-system learning	National learning system with transparent reporting, shared learning and open disclosure

Conclusion

The article suggested that Australian youth justice systems face systemic failure due to fragmented and superficial quality assurance mechanisms. Evidenced by thousands of unimplemented recommendations from various inquiries, with current systems primarily focused on reactive risk elimination. Suggestions for improvement included strengthening the regulatory environment so that standards are enforceable and auditable, strengthening 'implementation science' to embed change, and enhancing transparency, including the use of 'open disclosure' after harm occurs. The authors stated that overcoming systemic inertia requires the adoption of "service delivery frameworks centred on learning rather than blame."

Butcher, S., Muir, K., Maxwell, N., & Stewart, A. (2025). A national approach to safety and quality in Australian youth justice: Lessons from healthcare. *Australian Journal of Social Issues*. Advance online publication. https://doi.org/10.1002/ajs4.70079

Domestic and Family Violence Death Review and Advisory Board: Annual Report 2024–25

The 2024–25 Annual Report from the Queensland Domestic and Family Violence Death Review and Advisory Board (the Board) provides a critical analysis of domestic and family violence (DFV) related deaths, with a primary focus on homicides involving wilful fire-setting. The report's central investigation is a comprehensive 15-year case review (July 2009 - June 2024) of 16 DFV-related homicide events involving wilful fire-setting, which resulted in 31 deaths.

The case review found that wilful fire-setting is a devastating tool of coercive control, often preceded by explicit threats to kill or burn. The Board identified 4 major systemic issues, making corresponding recommendations to Government.

1. *Bystander Awareness and Action:* Enhance public health campaigns and develop training for workplaces and community members to recognise DFV warning signs and report threats safely.

2. *Appropriate DFV Services:* Increase the availability of nuanced, culturally safe, and tailored DFV services for diverse and vulnerable populations, including Aboriginal and Torres Strait Islander peoples, LGBTQI+ individuals, and those in regional and remote areas.

3. *Risk Assessment and Safety Planning:* Improve risk assessment frameworks, specifically by adding threats of fire or dousing to the Queensland DFV Common Risk and Safety Framework (CRASF) as a high-risk indicator and enhancing the integration of DFV-informed practices within mental health services.

4. *Data and Research:* Address persistent data gaps by systematically collecting data on fire-related threats within the DFV context and commissioning targeted research to better understand prevalence and inform prevention strategies.

In addition to the thematic review, the report provides a statistical overview of DFV-related homicides. In the 2024–25 period, there were 24 deaths, with 10 being intimate partner homicide, and 14 being familial homicide. All 6 deaths under the age of 18 were victims of familial homicide. Analysis of data from 2020–2025 indicates that while annual numbers fluctuate, there has been no significant increasing trend in the rate of DFV-related homicides.

Domestic and Family Violence Death Review and Advisory Board. (2025). *Queensland Domestic and Family Violence Death Review and Advisory Board Annual Report 2024–25.* Queensland Government. www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses

PeakCare: Annual Report for 2024–25

PeakCare's 2024–25 Annual Report highlights its role as Queensland's peak body for children and family services, specifically in the delivery of child protection, out-of-home care and related services. The report highlighted a number of key achievements of the organisation, as well as it's strategic focus.

1. *Workforce Development:* The Catalyst for Care Program was a cornerstone initiative, leading to the development of a co-designed Residential Care Workforce Strategy and a comprehensive refresh of the Hope and Healing Framework for trauma-informed practice.

2. *Sector Consultation:* The Sector Voices Roadshow engaged over 250 professionals, carers, and young people across Queensland. Resulting insights identified strains on the workforce (recruitment, retention, and limited career pathways) and whole of system concerns (red tape, inflexible contracts, and short-term funding cycles) as the most significant sector challenges.

3. *National Advocacy:* PeakCare is a founding member of the National Foster Care Sustainability Group, which successfully advocated for bipartisan federal support covering prioritised medical and therapeutic access and equitable leave entitlements for foster carers.

4. *Sibling Carers:* The National Sibling Carers Initiative was launched to gain formal recognition for siblings who become primary carers, ensuring they receive tailored support and that sibling rights to connection are upheld in care planning.

5. *Legislative Advocacy:* PeakCare actively opposed punitive youth justice reforms proposed in legislation such as the Making Queensland Safer Bill 2024 and the Adult Time, Adult Crime Amendment Bill 2025, arguing that detention increases recidivism and disproportionately affects First Nations children and young people.

Stewart, A., Rayment-McHugh, S., Allard, T., & Smallbone, S. (2025). *The links between childhood sexual abuse victimisation and adolescent offending (Trends & Issues in Crime and Criminal Justice No. 721).* Australian Institute of Criminology. https://www.aic.gov.au/sites/default/files/2025-11/ti721_links_between_childhood_sexual_abuse_victimisation_and_adolescent_offending.pdf
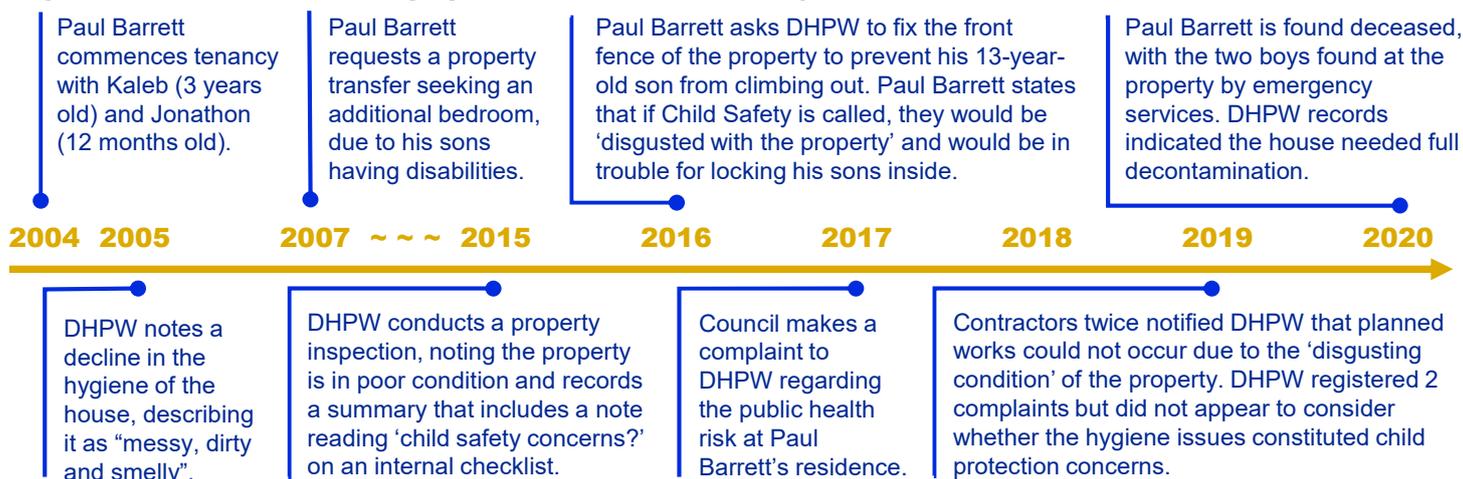
Queensland Ombudsman: Preventing harm to children with disability in Queensland

CHILD SAFETY   HOUSING

The Queensland Ombudsman has released a report titled "Preventing harm to children with disability in Queensland – Report 2: Department of Housing and Public Works". The Ombudsman's investigation was initiated in response to the case of Kaleb and Jonathon (pseudonyms), two young men with profound disabilities who experienced chronic neglect in a public housing property. The Ombudsman examined whether the Department of Housing and Public Works (DHPW) current practices and procedures are sufficient to prevent a similar event from occurring.

Key events of DHPW's engagement with the family

Paul Barrett commences tenancy with Kaleb (3 years old) and Jonathon (12 months old).

Paul Barrett requests a property transfer seeking an additional bedroom, due to his sons having disabilities.

Paul Barrett asks DHPW to fix the front fence of the property to prevent his 13-year-old son from climbing out. Paul Barrett states that if Child Safety is called, they would be 'disgusted with the property' and would be in trouble for locking his sons inside.

Paul Barrett is found deceased, with the two boys found at the property by emergency services. DHPW records indicated the house needed full decontamination.

2004 2005   2007 ~ ~ ~ 2015   2016   2017   2018   2019   2020

DHPW notes a decline in the hygiene of the house, describing it as "messy, dirty and smelly".

DHPW conducts a property inspection, noting the property is in poor condition and records a summary that includes a note reading 'child safety concerns?' on an internal checklist.

Council makes a complaint to DHPW regarding the public health risk at Paul Barrett's residence.

Contractors twice notified DHPW that planned works could not occur due to the 'disgusting condition' of the property. DHPW registered 2 complaints but did not appear to consider whether the hygiene issues constituted child protection concerns.

Key issues identified by the Ombudsman

Fragmented information systems
Critical child protection information recorded during property inspections does not automatically replicate to tenancy management systems, creating information silos that can lead to officers overlooking crucial details and patterns of harm.

Inadequate response protocols
Guidance for staff is inconsistent regarding when to consult managers, how to assess information from contractors for child protection risks, and whether reporting suspicions of harm is mandatory.

Underutilisation of specialist resources
The in-house Specialist Response Team (SRT), established to assist with complex cases, is not adequately promoted within child protection procedures and lacks its own documented practices and training.

Lack of oversight and training
Housing has no formal quality assurance processes, such as audits, to monitor compliance with child protection reporting. Furthermore, it does not provide regular, mandatory child protection training for its officers.

Procedural gaps
Deficiencies were identified in complaints management, where child protection concerns could be overlooked before a case is closed, and in providing officers with practical guidance on applying human rights considerations.

DHPW reviewed the proposed report and provided responses, generally acknowledging the identified concerns and opportunities for improvement, and committed to addressing the recommendations made by the Ombudsman.

The Ombudsman's recommendations

The Ombudsman made 11 recommendations to DHPW. These primarily focused on requiring mandatory, targeted training (Recommendation 11), amending the flow of child protection data between internal systems (Recommendations 2 and 5), formalizing consultation requirements (Recommendation 1), introducing procedures for responding to contractor warnings (Recommendation 4), and clarifying the roles and use of the Specialist Response Team (Recommendations 7 and 8).

DHPW acknowledged that it had already undertaken a significant amount of work since the investigation began to review and amend procedural information for staff regarding reporting child protection concerns. However, the department acknowledged there were "further opportunities to strengthen guidance for staff" by using consistent language, clearly defining roles and appropriate delegation levels, and ensuring staff apply a 'consideration lens to the department's practices and procedures.

Key Findings from AIHW Specialist Homelessness Services Data (2024-25)

CHILD SAFETY   HOUSING

The latest Australian Institute of Health and Welfare (AIHW) Specialist Homelessness Services (SHS) 2024–25 data provided new insights into the scale and characteristics of homelessness and housing instability among Queensland children, young people and families. Additional sub-group data highlight the overlap between homelessness, family vulnerability, and statutory systems.

Overview (Queensland and Australia)

SHS service use and presenting needs showed that:

- **54,700 clients** were assisted in Queensland in 2024–25 (19 per cent of national SHS clients).
- **61 per cent** of Queensland clients were **homeless at first presentation** (national: 49 per cent).

The primary reasons for assistance in Queensland was:

- Housing affordability stress: 50 per cent (national: 36 per cent)
- Financial difficulties: 50 per cent (national: 41 per cent)
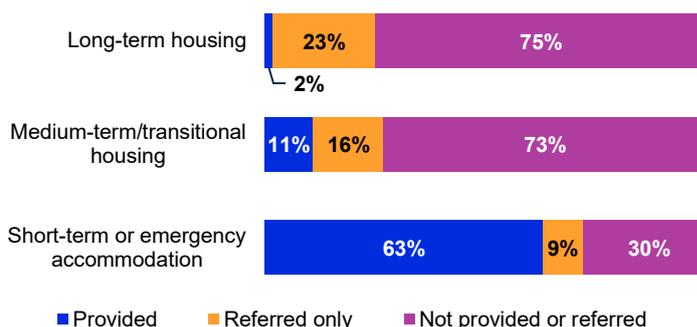- Housing crisis: 45 per cent (national: 38 per cent)
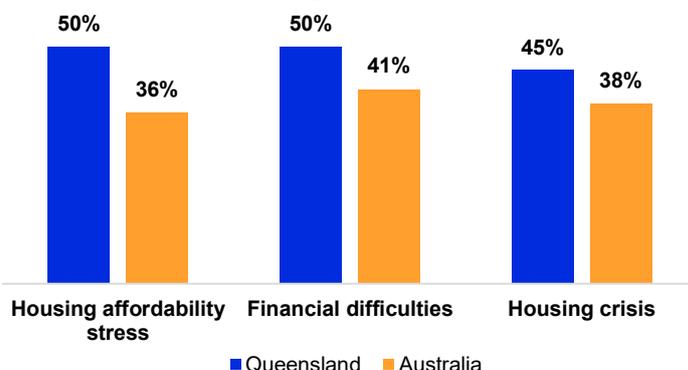
Housing support needs in Queensland

In Queensland, 66 per cent of QLD clients needed accommodation, higher than the National figure of 59 per cent. The Provision rates:

- Long-term housing: 2 per cent provided
- Medium-term: 11 per cent provided
- Emergency accommodation: 63 per cent provided
- Housing outcomes: 30 per cent of clients beginning homeless were assisted into housing. 89 per cent of clients at risk maintained housing.

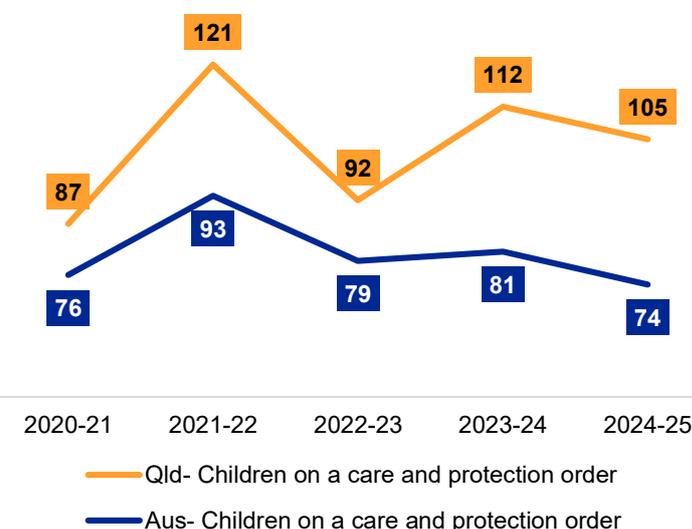## Children, young people and SHS involvement

Nationally:

- 40,500 children and young people presented alone to SHS (14 per cent of all SHS clients).
- 8,500 children on care and protection orders (CPOs) received SHS (3 per cent of all SHS clients)
- The most common main reason children aged 12-17 sought assistance was relationship/family breakdown, while young people aged 18-24 identified housing crisis (e.g., eviction).

In Queensland:

- QLD rate of children on CPOs accessing SHS: 16.7 per 10,000 (national: 14.7).
- 36.8 per cent of children on CPOs in Queensland experienced Family and Domestic Violence issues, a current mental health issue, or both.
- Children on CPOs in Queensland received a median of 87–121 nights of accommodation over the past five years, consistently higher than the national median (74–93 nights).

Median number of nights accommodated

Median number of nights accommodated — Queensland vs Australia:
- Housing affordability stress: Queensland 50%, Australia 36%
- Financial difficulties: Queensland 50%, Australia 41%
- Housing crisis: Queensland 45%, Australia 38%

Queensland housing support need and services provided

- Long-term housing: Provided 2%, Referred only 23%, Not provided or referred 75%
- Medium-term/transitional housing: Provided 11%, Referred only 16%, Not provided or referred 73%
- Short-term or emergency accommodation: Provided 63%, Referred only 9%, Not provided or referred 30%

■ Provided   ■ Referred only   ■ Not provided or referred

Median number of nights provided to children on care and protection orders

	2020-21	2021-22	2022-23	2023-24	2024-25
Qld- Children on a care and protection order	87	121	92	112	105
Aus- Children on a care and protection order	76	93	79	81	74

UNICEF and ARACY: The State of Australia's Children report

CHILD SAFETY   **YOUTH JUSTICE**

The State of Australia's Children 2025 report is a comprehensive, evidence-based analysis produced by UNICEF Australia and the Australian Research Alliance for Children and Youth (ARACY). The report found that despite possessing adequate resources to ensure every child thrives, ongoing systematic issues are leaving significant numbers of children behind.

While The State of Australia's Children report highlights several positive trends, the areas of progress are often overshadowed by ongoing challenges. The report states that further investment in prevention, early intervention, and community-led solutions is "economic commonsense," with the aim to build a society where every child is given the same opportunity to thrive. Structured to align with ARACY's *The Nest* wellbeing framework, the report provides numerous 'data snapshots' to substantiate the assessment of each domain.

Key areas of concern

Inequity and discrimination

While national averages may suggest positive outcomes, they mask significant disparities for children who are Aboriginal or Torres Strait Islander, gender diverse, living with a disability, growing up in poverty, or residing in rural and remote areas.

Examples include:

- **Nearly 1 in 3 (29.7 per cent) and 2 in 5 (41.8 per cent) Aboriginal and Torres Strait Islander children and young people**, and **44 per cent of children and young people with a disability** report experiencing discrimination in the past year.

- Only **33.9 per cent of Aboriginal and Torres Strait Islander children are developmentally on track** across all five domains when starting school, compared to the national figure of 52.9 per cent.

Cost of living and productivity

Despite improvements in employment rates, cost-of-living pressures are eroding the wellbeing of children and families, contributing to worsening outcomes in health, housing, and nutrition.

Examples include:

- **Nearly 1 in 4 people experiencing homelessness are aged 12–24**. 1 in 3 young people leaving out-of-home care become homeless within a year.

- **1 in 6 children in Australia lives in poverty**. This rate is estimated to have increased between 2021 and 2022 due to rising living costs.

Increasing pressures in adolescence

The transition into adolescence is marked by new and complex challenges, including rising social pressures, identity formation, and systemic stressors affecting mental health and connection.

Examples include:

- **1 in 5 young people aged 18–24 (20.2 per cent) report high or very high psychological distress**, a 5 per cent increase since 2017–18. Wait times for mental health services average 99 days.

Child protection and youth justice

Australia's child protection and youth justice systems are failing to safeguard the rights and wellbeing of vulnerable children, particularly Aboriginal and Torres Strait Islander children, who are disproportionately represented in both systems.

The data trends for this theme are addressed further in this paper.

Early years and developmental vulnerability

Despite high enrolment in early childhood education, developmental vulnerability remains persistent and a growing challenge, suggesting the need for greater focus on foundational early years.

Examples include:

- **23.5 per cent of children are developmentally vulnerable on one or more domains when starting school**, the highest level recorded since 2009.

Data gaps

Despite having "robust data infrastructure", the report states that children's experiences are not adequately reflected in state, national, and aggregated data. The report presents several of these challenges, such as;

- **Inadequate data relating to child protection, out-of-home care, and youth justice systems**, often leaving these children underrepresented or missing entirely from statistics that guide funding and policy.

- **Fragmented and inconsistent data systems**, making it difficult to track children's experiences over time. These are often based primarily on identity factors such as disability, cultural background, and care experience.

- **Limited routine reporting on key wellbeing indicators** (including mental health, discrimination, and safety), and a lack of longitudinal data. The lack of this data obscures the long-term impacts of early disadvantage and prevents effective evaluation of interventions over time.

O'Connell, M., et al. (2025). *The State of Australia's Children 2025*. ARACY and UNICEF Australia. https://www.unicef.org.au/the-state-of-australia-s-children
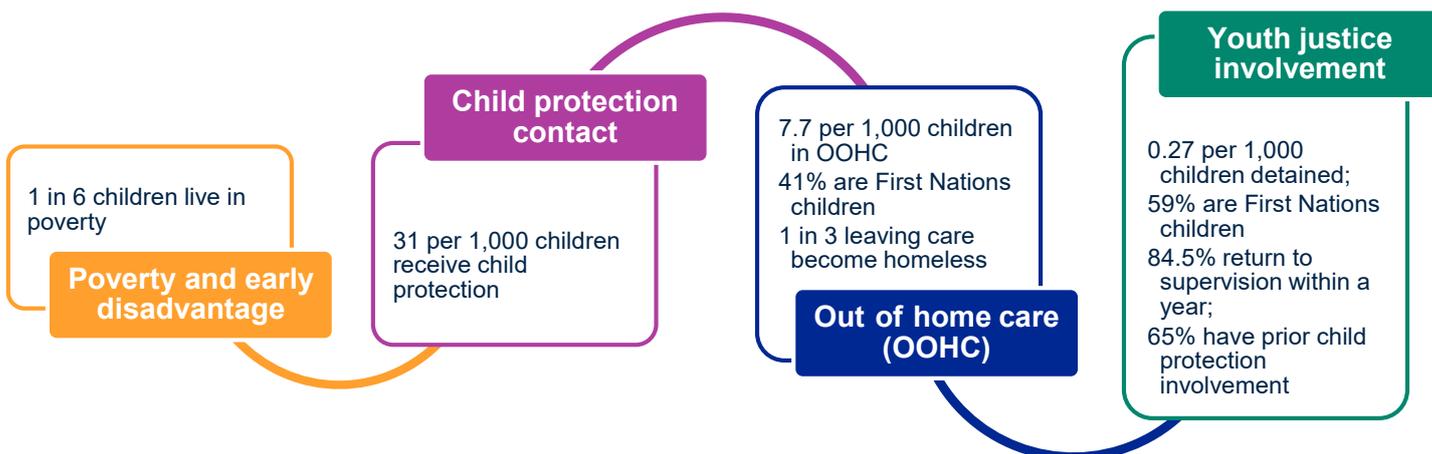
Child protection, out-of-home care and youth justice

Falling primarily under the *Valued, Loved and Safe* domain, the report analysed data in relation to the child protection and youth justice systems in Australia, finding that these systems often undermined children's rights and impacted their wellbeing, with these effects amplified for marginalised groups.

Key systems and impacting children and young people in Australia include:

Poverty and early disadvantage
1 in 6 children live in poverty

Child protection contact
31 per 1,000 children receive child protection

Out of home care (OOHC)
7.7 per 1,000 children in OOHC
41% are First Nations children
1 in 3 leaving care become homeless

Youth justice involvement
0.27 per 1,000 children detained;
59% are First Nations children
84.5% return to supervision within a year;
65% have prior child protection involvement

Child protection and out-of-home care

The rate of children in OOHC saw a slight, slowing decline to 7.7 per 1,000 in 2023–24, while the rate of children receiving child protection services remained stable at 31 per 1,000 in the same period.

Impact of external factors: Children residing outside major cities face elevated rates of placement in out-of-home care, and children born to mothers aged 21 and under are 3.5 times more likely to be known to child protection in New South Wales.

Overrepresentation: Aboriginal and Torres Strait Islander children are severely overrepresented, making up 41 per cent of children in OOHC and being 10 times more likely to be in care than non-Indigenous children. Current trends suggest this overrepresentation is projected to increase by 38 per cent by 2034, and the relevant Closing the Gap target is currently not on track. Only 15 per cent of government child protection funding is spent on prevention, with just 6 per cent allocated to Aboriginal Community Controlled Organisations (ACCOs).

Cultural disconnection: Care provided to Aboriginal children often lacks connection to culture, kin, and Country, which compounds trauma.

Cost: Annual government expenditure on child protection exceeds $10 billion, but this spending is heavily weighted toward treating symptoms, such as high-cost emergency accommodation, rather than supporting prevention or early family strengthening.

Youth justice

The rate of youth detention (ages 10–17) in 2023–24 was 0.27 per 1,000, a rate that has plateaued since 2019–20 despite an overall decline in youth offending over the last decade.

Punitive approaches: The youth justice system is criticised for favouring punitive methods over restorative ones, and for detaining children as young as 10, one of the world's lowest ages of criminal responsibility, often while they are awaiting sentencing (representing 80 per cent of children in youth justice systems nationally).

Overrepresentation: Aboriginal and Torres Strait Islander children are chronically overrepresented, making up 59 per cent of those in detention despite comprising only about 5.7 per cent of the youth population. Their detention rate is approximately 27 times that of non-Indigenous children, and this rate has increased nationally since 2019-2020.

Recidivism and Disadvantage: Recidivism is high, with 84.5 per cent of those released from detention returning to sentenced supervision within a year. Those detained are often the most disadvantaged, with 65 per cent of young people under youth justice supervision in 2022–23 having had prior contact with the child protection system in the last decade.

Cost: Government expenditure on youth justice systems is approximately $2.2 billion per year, which accounts for ten percent of the entire cost of late intervention.

O'Connell, M., et al. (2025). *The State of Australia's Children 2025*. ARACY and UNICEF Australia. https://www.unicef.org.au/the-state-of-australia-s-children

SNAICC 2025 Family Matters report – key findings and recommendations for Queensland

CHILD SAFETY **OVER-REPRESENTATION**

The *Family Matters Report 2025* is SNAICC's annual national assessment of progress toward ensuring Aboriginal and Torres Strait Islander children grow up safe, cared for, and connected to family, community and culture. It tracks government action to reduce over-representation in child protection and OOHC, highlights systemic challenges, and elevates community-led solutions.

Drawing on national data, jurisdictional updates and community insights, the report is structured around:

- **Indicators & trends** – departmental intervention patters, data gaps, structural drivers, and over-representation projections.
- **Year in review** – key policy, legislative and program changes across states and territories.
- **Recommendations** – reforms aligned with the Family Matters Building Blocks and national frameworks such as Closing the Gap and Safe and Supported.

National findings

- *Growing gap between commitments and lived experience:* despite strong policy rhetoric, actions are falling behind commitments. There is a widening gap between what governments says and what First Nations communities are experiencing.

- *Over-representation persists across the child protection continuum:* The report identifies structural drivers of child protection involvement, which include intergenerational trauma, racism, socioeconomic disadvantage, housing instability, and family violence.

- *Prevention investment declining proportionally:* The report highlights that the proportion of funding going to early intervention and prevention has reduced over the past five years. The report states that **only 15.6 per cent of government expenditure goes to family support services**.

- *Community-controlled sector continues to show strong leadership:* The report includes multiple examples of Aboriginal community-controlled organisations (ACCOs) delivering culturally grounded, effective programs.

- *Building Blocks remain the central framework:* The report reiterates the importance of the four Family Matters Building Blocks; culturally safe universal and targeted services, Aboriginal decision-making, responsive law, policy and practice, and accountability to First Nations peoples.

Queensland findings

- *Rising over-representation in OOHC (five consecutive years):* The Queensland Commissioner for Aboriginal and Torres Strait Islander Children reports: After stabilisation from 2017-202, the rate of Aboriginal and Torres Strait Islander children in care has **increased for five consecutive years.**

- *Queensland has more Aboriginal and Torres Strait Islander children in care than before:* The Commissioner states that Queensland now has the **highest number of Aboriginal and Torres Strait Islander children in care in its history.**

- *Implementation and cultural leadership:* The Commissioner notes an erosion of cultural leadership across policy settings, alongside reduced momentum and inconsistent implementation of reform commitments.

- *Sector challenges affecting community-controlled organisations include:* Rising referral volumes, inconsistent departmental engagement, and capacity pressures in Family participation Program and Family Wellbeing services.

- *Delegated Authority expansion (major growth):* The report stated that Delegated Authority has grown 310 per cent since 2022, now including 19 service responses, delivered by 14 ATSICCOs across 25 child safety service centres.
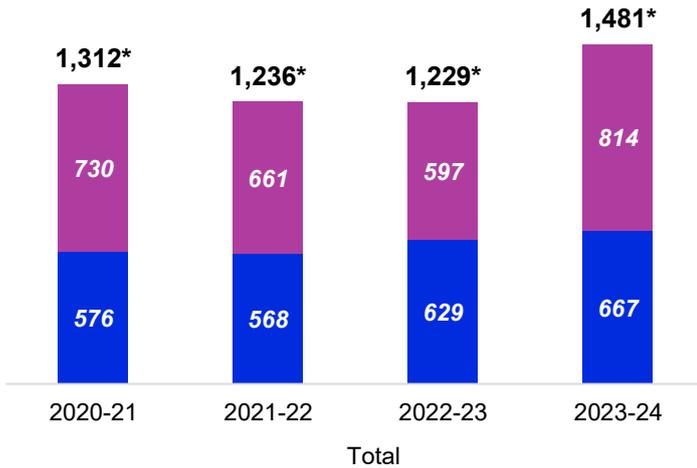
In summary

- **Nationally**, over-representation of Aboriginal and Torres Strait Islander children in child protection continues, driven by structural inequities and insufficient investment in prevention.

- **Queensland** is experiencing a sustained increase in Aboriginal and Torres Strait Islander children in care (five consecutive years).

- **Delegated Authority** shows substantial growth in QLD (310 per cent), but system pressures and inconsistent engagement remain challenges.

- **Community-controlled leadership** is a consistent strength nationally, while government implementation and accountability continue to lag.

- The **Family Matters Building Blocks** continue to provide the core reform framework but require genuine commitment and resourcing from governments.

Key Findings from AIHW Safety of Children in Care Data (2024-25)

CHILD SAFETY

The Australian Institute of Health and Welfare (AIHW) has published updated data for the child protection sub-topic, 'Safety of children in care'. This data presents the numbers of substantiations of abuse in care in Australia and has not reported data by state and territory since 2021-22. The report notes that differences in processes, data systems and record keeping methods makes comparisons between jurisdictions problematic. The data includes substantiations recorded between 1 July 2023 to 30 June 2024.
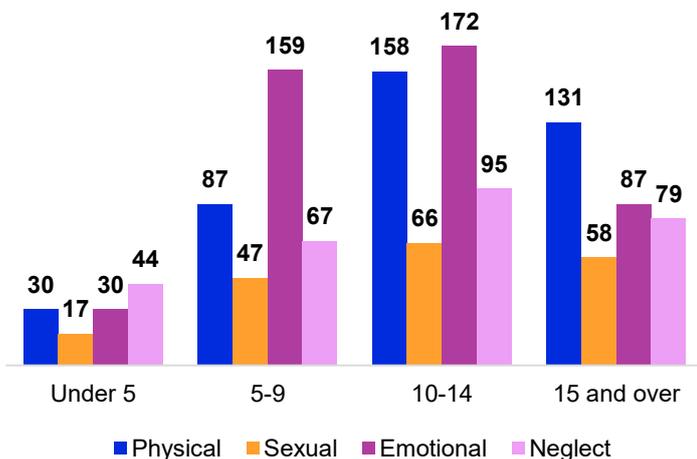
Number of children subject to a substantiation

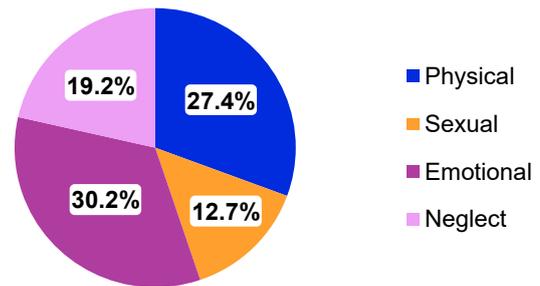|	2020-21	2021-22	2022-23	2023-24
Total	1,312*	1,236*	1,229*	1,481*
Emotional	730	661	597	814
Physical	576	568	629	667

Total

Despite decreasing for two years since 2020-21, the number of substantiations in 2023-24 is higher than the total number of substantiations in 2020-21.

Prevalence of primary type of abuse by age group

The most common type of substantiated abuse was observed to vary across different age groups.

For children aged under 5, the predominant type of abuse was neglect (31 per cent or 44 substantiations).

Emotional abuse was most common for children aged 5–9 (40 per cent or 160 substantiations), as well as children aged 10–14 (31 per cent or 170 substantiations).

Among children aged 15 and over, the most frequently substantiated abuse was physical abuse (34 per cent or 130 substantiations).

	Under 5	5-9	10-14	15 and over
Physical	30	87	158	131
Sexual	17	47	66	58
Emotional	30	159	172	87
Neglect	44	67	95	79

Primary type of substantiated abuse in care

- Physical — 27.4%
- Sexual — 12.7%
- Emotional — 30.2%
- Neglect — 19.2%

Emotional abuse was the most common type of substantiated abuse in care, with 448 children substantiated in 2023-24. Sexual abuse was the least common, with 188 children substantiated in 2023-24.

The rates of the primary type of abuse were similar for First Nations children and non-Indigenous children. Prevalence of primary type of abuse was also similar for males and females.

Improving national datasets

The national strategy for improving safety in care data centres on enhancing the **Child Protection National Minimum Data Set** (CPNMDS), which AIHW uses for national reporting. Key actions and future plans include:

- The CPNMDS was established in response to three Royal Commission recommendations concerning child sexual abuse, though the collection covers physical abuse, emotional abuse, and neglect as well.

- State and territory governments agreed to implement data reforms, specifically prioritizing enhancements to the CPNMDS and developing nationally consistent definitions for child sexual abuse terms and child sexual exploitation.

- Future reporting will provide a more complete picture by including data on children who were the subject of multiple substantiations and/or types of abuse, expanded details on when and where the abuse occurred and who perpetrated it, and a 'best estimate' of the rate of abuse among all children in care.