February 2026

Sector Insights paper

In this month's Insights paper

QUEENSLAND Family & Child Commission

Queensland Government

Report on Government Services 2026
Section 16: Child Protection Services – key findings for Queensland

Child Safety

The *Report on Government Services* (RoGS) is an annual national performance report produced by the Productivity Commission. It provides comparable, standardised data across states and territories on the equity, effectiveness and efficiency of government services, including child protection and youth justice.

Due to the transition to the Unify information system, a large proportion of Queensland data was not reported this year.

For the first time, Queensland recorded the highest real expenditure on care services in the nation, with an increasing share spent on out-of-home care and other supported placements.

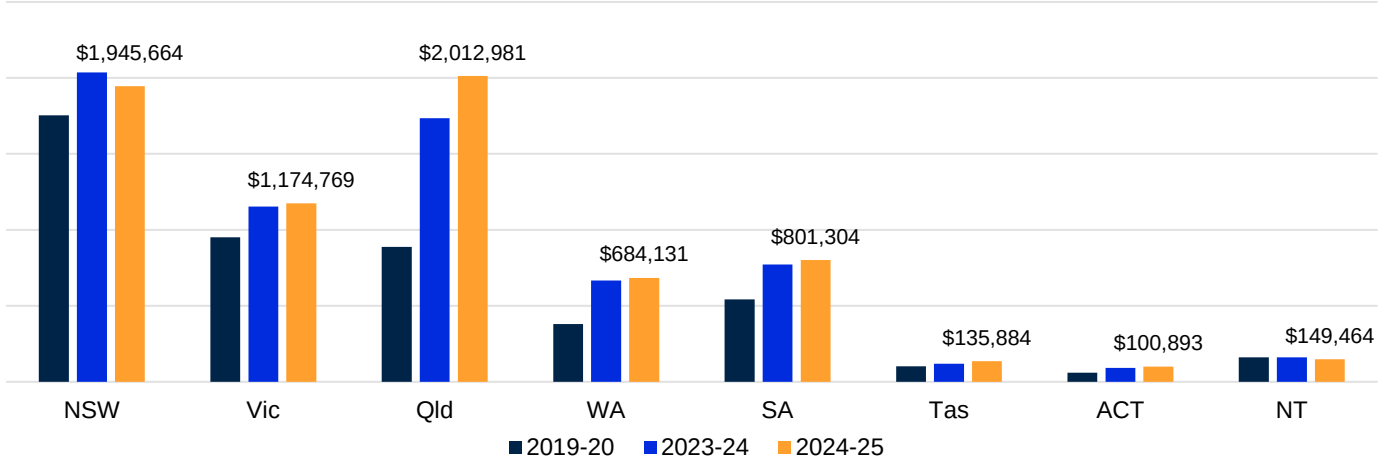
In 2024-25, Queensland surpassed all other states and territories in total expenditure on care services.

- In 5 years, expenditure on care services increased from **$887,885** in 2019–20 to **$2,012,981** in 2024–25. *This figure may have been impacted by machinery-of-government changes.*

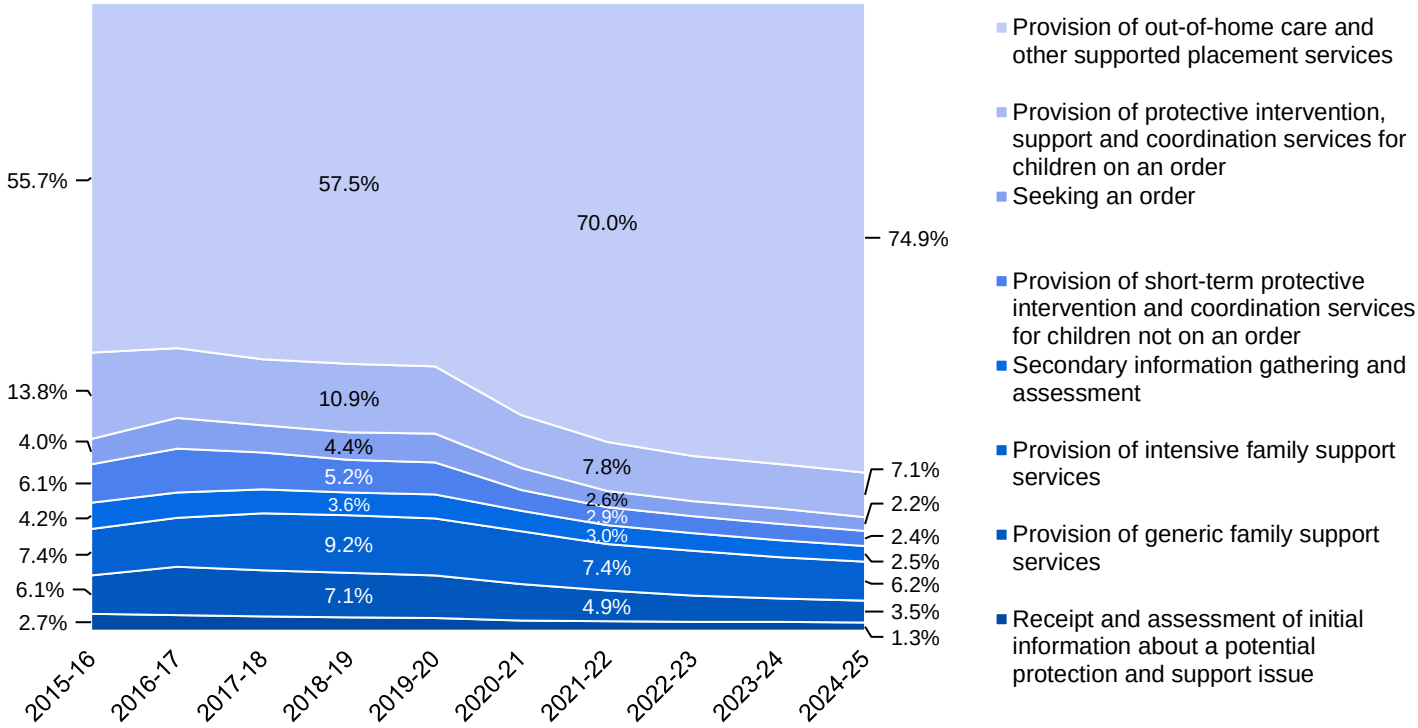
The proportion of total expenditure allocated to out-of-home care and other placement services increased from **55.7 per cent** in 2015–16, to **74.9 per cent** in 2024–25.

Child protection services – Queensland findings

Real government expenditure on care services, by jurisdiction and year - *Table 16A.38*



Proportion of total expenditure by activity group costs by year - *Table 16A.29*



Productivity Commission. (2026). *Report on Government Services 2025: Child protection*. Australian Government https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/

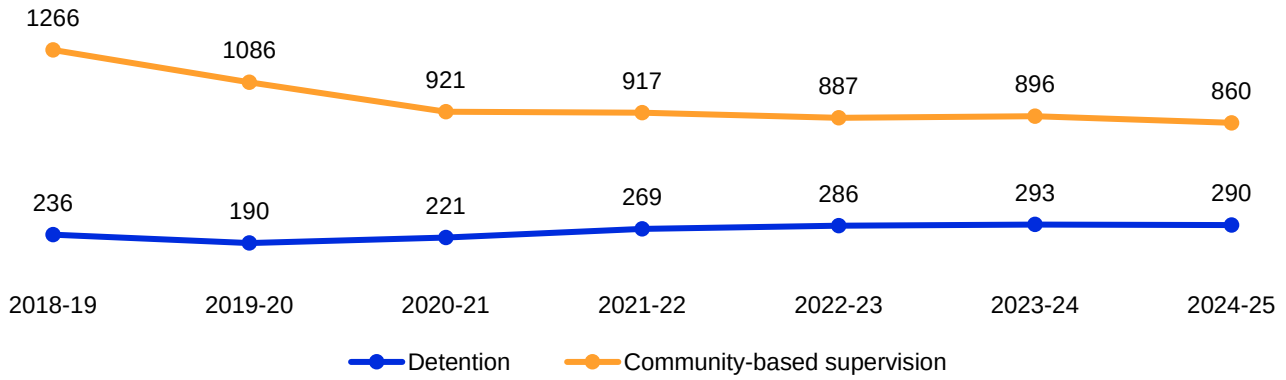
Report on Government Services 2026
Section 17: Youth justice services – key findings for Queensland

Youth Justice | Over-representation

Youth justice services – Queensland findings

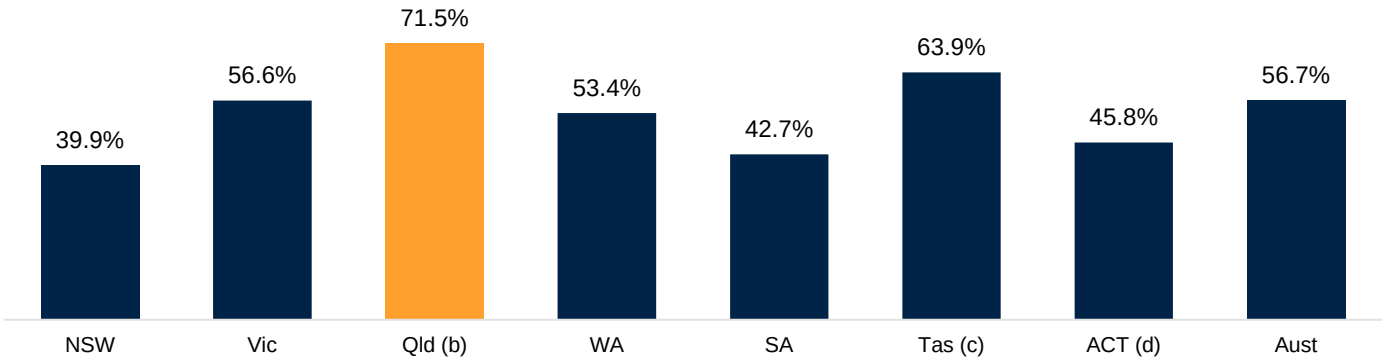
Following the statutory inclusion of 17-year-olds in the youth justice system in February 2018, ROGS data from 2018–19 onwards establishes a new baseline for the expanded cohort. The subsequent reporting periods show variance in the average daily number of young people in detention and community-based supervision across the seven-year timeframe.

Average daily number of young people aged 10-17 years under youth justice supervision - *Table 17A.1*



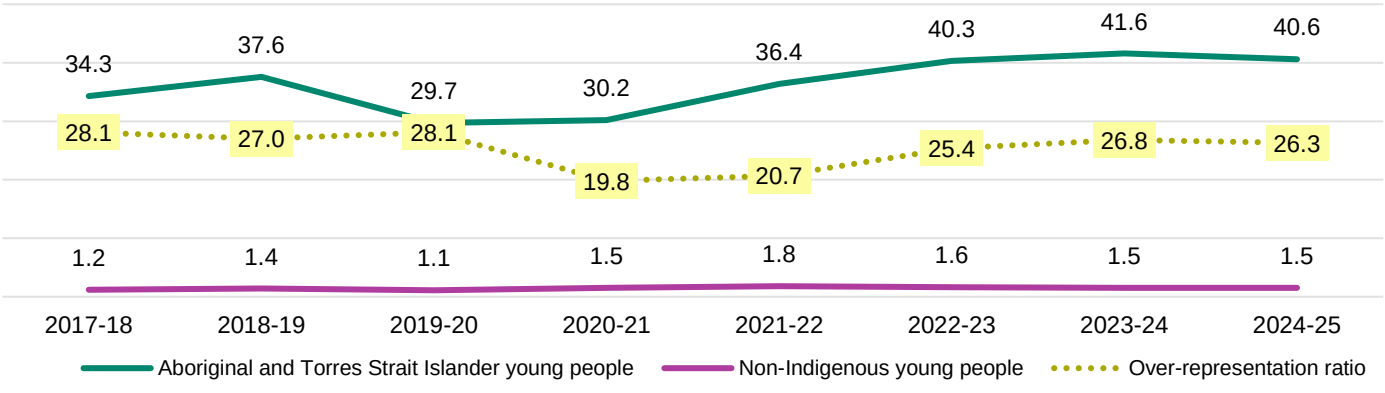
The proportion of young people who return to sentenced supervision within 12 months of release has increased in Queensland and remains higher than any other jurisdiction (Northern Territory did not report in 2024-25).

Proportion of young people released from sentenced supervision in 2022–23, who returned to sentenced supervision within 12-months- *Table 17A.26*



Aboriginal and Torres Strait Islander young people are 26 times more likely to be in detention compared to non-Indigenous young people. The over-representation ratio is 26.3 in 2024-25.

Rate per 10,000 young people in detention in Queensland, by Indigenous status- *Table 17A.7*



Productivity Commission. (2026). *Report on Government Services 2025: Child protection*. Australian Government. https://www.pc.gov.au/ongoing/report-on-government-services/community-services/youth-justice/

Communities That Care (CTC): Evidence from a mixed methods systematic review

Youth Justice | Substance abuse

The Communities That Care (CTC) technical report presents a mixed methods review of the CTC prevention framework. It includes:

- A **multi-level meta-analysis (MLMA)** of impact studies assessing effects on **youth violence and offending behaviour** (13 studies; 41 effect sizes).
- A narrative review of implementation papers (n=24) linked to the impact evidence.

CTC is grounded in the Social Development Model and focused on identifying and addressing elevated community-level risk factors while strengthening protective factors.

Summary of Meta-analysis findings

The meta-analysis concludes that the Communities That Care (CTC) prevention system has not yet been sufficiently tested. Of the included studies, CTC was associated with an **estimated 7% reduction in youth violence**, but this effect:

- Was not statistically significant
- Represents a small effect size
- Is supported by a low level of certainty
- May be underpowered due to the small number of studies

Although the 7% reduction could be socially meaningful at a population level, the report emphasises that the estimate is **uncertain and should be treated cautiously.**

CTC is a coalition-based operating system that guides communities:

a) Getting started (assess community readiness and recruit)

b) Getting organised (establish a community coalition)

c) Developing a community profile (identify priority risk and protective factors)

d) Creating a community action plan (plan the implementation of selected effective programmes)

e) Implementing and evaluating

Moderation and Subgroup Findings

There was **no statistically significant moderation by study location**.

CTC appeared to perform similarly across:

- urban and rural settings
- international contexts (including Australia and multiple U.S. states).

However, this interpretation is limited by the small number of studies and inability to test within-study differences.

Subgroup analysis by behaviour type suggested:

- **a 13% reduction in violence**
- **a 3% reduction in delinquency.**

This difference did **not reach statistical significance** and is associated with **low certainty**, potentially due to low statistical power.

Implementation and delivery considerations

- Addressing **implementation challenges**, particularly recruitment to higher-need evidence-based programmes (e.g., parenting programs, afterschool programs, programs for young people not in school).
- Encouraging coalitions to select both universal evidence-based programmes, and targeted programmes for higher-risk groups

Summary

The current evidence base is limited in scope and power. Strengthening implementation, improving evaluation consistency, and conducting additional independent trials are necessary to clarify the effectiveness and mechanisms of CTC.

Youth Endowment Fund. (2025). Communities That Care (CTC): Technical report. Youth Endowment Fund. https://www.youthendowmentfund.org.uk/

Improving mental health outcomes for children and young people in out-of-home care

Child Safety | Adolescent mental health

Children and young people in out-of-home care (OOHC) experience high rates of complex and chronic mental health needs, largely linked to experiences of maltreatment and trauma. While targeted programs exist in some jurisdictions, Australia currently lacks a systemic, nationally integrated approach to meeting the mental health needs of this cohort. Practitioners report that mental health care remains fragmented, reactive, and insufficient, leaving many needs unmet.

The current study

- The study sought to identify key enablers that the OOHC sector can leverage to improve mental health outcomes for children and young people while they are in care.
- Semi-structured interviews were conducted with 27 OOHC practitioners across five Australian states and territories, including case workers, therapeutic specialists, practice leaders and executive leaders.
- Practitioner insights were analysed thematically and mapped to a bioecological model, enabling identification of enablers operating across individual, relational, community and structural levels.
- The study builds on earlier literature by validating previously identified enablers and identifying additional **practitioner-derived enablers** to inform more comprehensive, system-oriented responses to mental health in OOHC.

Key findings

Practitioners endorsed all 11 mental health enablers previously identified in the literature and identified four additional enablers that were less visible in existing research.

The enablers are mapped across a bioecological model to show how mental health outcomes for children and young people in out-of-home care are influenced by interacting factors at individual, interpersonal, institutional and structural levels, with practitioner-identified enablers emphasising system-level conditions beyond individual service responses.

Four practitioner-identified enablers

Interpersonal

1. Connection to community
- Community, cultural, family and peer connections were seen as protective for mental health
- Early and sustained connections were viewed as critical, particularly to support transitions from care into adulthood

Institutional

2. An empowered, sustainable workforce
- High staff turnover, burnout, and moral injury undermine continuity, safety and therapeutic relationships
- Practitioners emphasised the need for stable staffing, reflective practice, and clearly defined therapeutic frameworks

3. In-house clinical teams embedded within OOHC services
- External mental health services were described as difficult to access, slow, and poorly matched to OOHC complexity
- Integrated, multidisciplinary in-house teams enabled timely responses, relational continuity, and coordinated care

Structural

4. Collective investment in youth mental health
- Practitioners identified societal stigma, moral panic, and limited trauma literacy as barriers to reform
- Under-investment across early intervention, therapy, and workforce capability was seen as constraining system change

Practitioners described improved mental health outcomes for children and young people in out-of-home care as dependent on coordinated, system-level approaches rather than fragmented or crisis-driven responses. The study identifies workforce sustainability, embedded clinical teams, community connection, and collective investment in youth mental health as additional practitioner-derived enablers that complement those previously identified in the literature.

Harris, Higgins & Willis (2026) – *Practitioners' perspectives on enablers of improved mental health outcomes for children and young people in out-of-home care.* https://www.sciencedirect.com/science/article/pii/S2950193826000070

The prevalence and prevention of child sexual abuse and sexual harassment in faith-based settings

Child safety | Child safeguarding | Child sexual abuse

This doctoral research addressed questions about the prevalence, nature, and prevention of child sexual abuse and peer sexual harassment, with a particular focus on faith-based settings.

Across five interrelated studies, the research examined:

- National prevalence of child sexual abuse perpetrated by leaders or adults within religious organisations
- The prevalence and age of onset of peer sexual harassment
- Definitions and conceptualisations of harmful sexual behaviours
- Prevention approaches in faith-based contexts
- Religious leaders' perspectives on safeguarding practices

Key findings

1. Prevalence of adult-perpetrated abuse in faith-based settings

Analysis of the Australian Child Maltreatment Study (ACMS) data revealed:

- approximately **0.4% (1 in 250)** of participants experienced child sexual abuse by a leader or adult within an Australian religious organisation
- the average age of onset was between 7 and 11 years
- abuse disproportionately affects men during their childhoods compared to women and is overwhelmingly perpetrated by men, particularly men in positions of power
- incidents were most frequently reported in **Catholic organisations**
- although rates have declined over time among men, the abuse has still affected an estimated **87,000 Australians**, with significant consequences for individuals, families and communities.

2. Trends in peer sexual harassment

The research reports that:

- Peer sexual harassment has increased significantly over time, and it can include behaviours such as saying, writing, or doing something sexual that is offensive or intimidating.
- Girls and gender- and sexuality-diverse young people experienced higher rates of peer harassment, most often perpetrated by boys.

These patterns indicate the importance of prevention strategies that directly address gendered power dynamics, social norms, and institutional cultures that may permit or normalise harmful behaviours.

3. Safeguarding practice and leadership insights

Interviews with religious leaders highlighted:

- Strengthening of safeguarding through increased leadership commitment, policy development, and training related to adult-perpetrated abuse.
- Ongoing barriers including: cultural resistance to change, hierarchical authority structures, limited focus on risks between peers, and over-reliance on compliance-driven safeguarding processes.

The proposed safeguarding model

Drawing on these findings, the thesis introduces a **Theological–Organisational Model for Safeguarding**, which:

- integrates socioecological theory with contextual frameworks
- examines how individual, institutional, theological, and societal factors interact in faith-based settings
- advocates for a shift away from procedural compliance towards deeper cultural and structural transformation.

Conclusion

The thesis demonstrates that child sexual abuse within faith-based settings has affected a substantial number of Australians, that peer sexual harassment is rising, and that effective safeguarding requires systemic, contextually informed, and theologically grounded approaches.

Hunt, L. (2025). The prevalence and prevention of child sexual abuse and sexual harassment in faith-based settings (Doctoral thesis, Australian Catholic University).

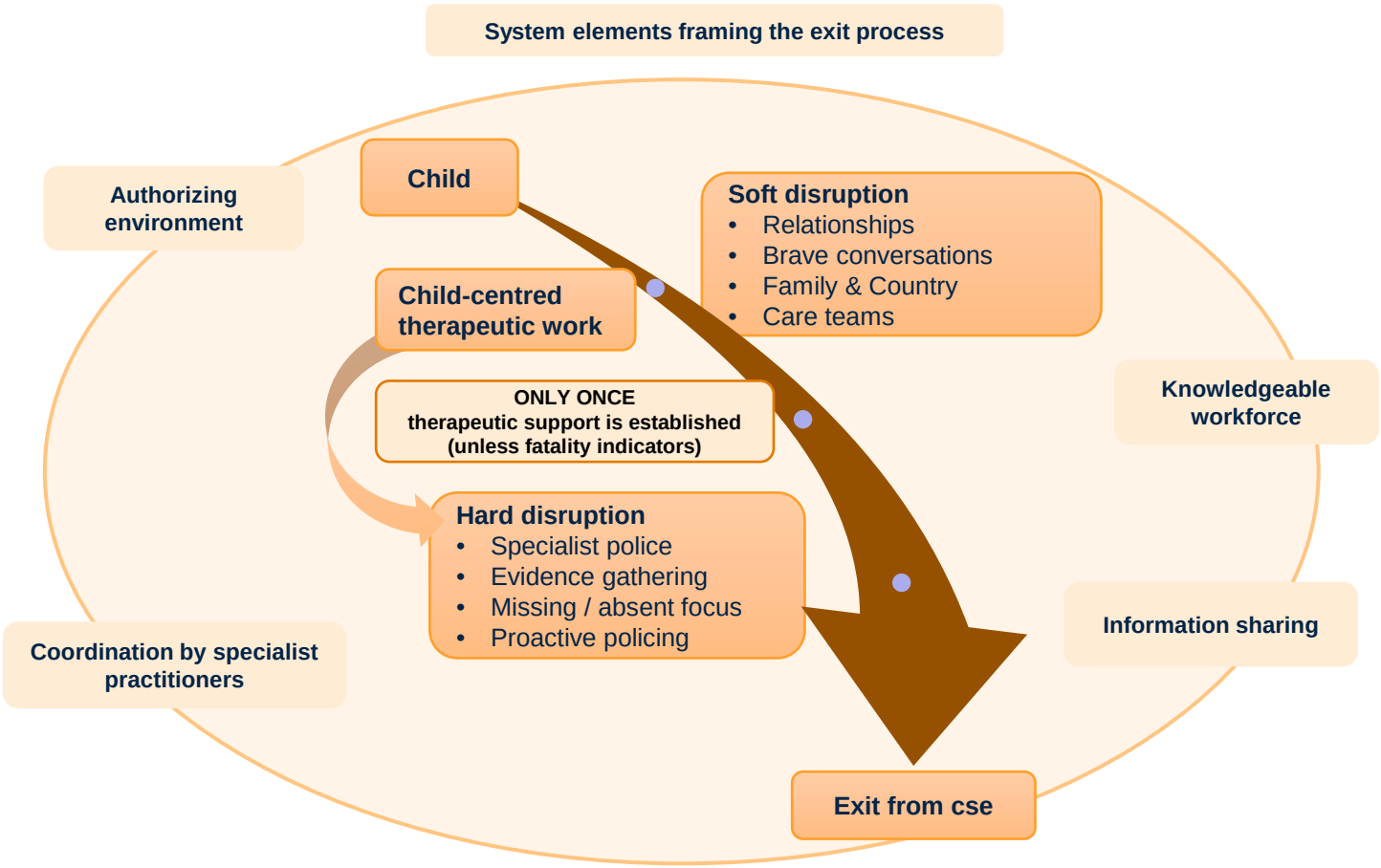
Disrupting child sexual exploitation: A cautionary tale

Child safety | Child sexual abuse

The study explored how practice experience can inform a model to support children living in residential out-of-home care to exit child sexual exploitation (CSE). Using a practice-led qualitative approach, the authors analysed interviews and focus groups with child protection workers, residential care staff, and community service practitioners across Australia who were involved in CSE responses.
The explicit research question was: *How does practice experience inform the development of a model to exit children from CSE?*

Core finding: a CSE Exit Model

The model is for both Aboriginal and non-aboriginal children living in residential care.



- The model depicts a pathway in which the child is positioned at the centre, with therapeutic work forming the necessary foundation for subsequent intervention. Once therapeutic support is established, soft disruption strategies, such as relationship-based practice, brave conversations, family and cultural connection, and coordinated care teams, can be implemented to address the push and pull factors associated with exploitation.
- **Hard disruption strategies**, including specialist police involvement, evidence gathering, attention to missing or absent episodes, and proactive policing of persons of interest, are undertaken **only after** therapeutic support is in place, as premature hard disruption may cause further distress and trauma. Together, these elements support a pathway toward exiting children from sexual exploitation, while maintaining a child-centred and trauma-informed approach.
- The exit pathway shown in the figure is framed by four system elements identified in the study: an authorising environment, information sharing and multi-agency work, coordination by expert cse practitioners, and a knowledgeable workforce. These elements operate across all stages of the exit process and enable effective sequencing and coordination of therapeutic work, soft disruption, and hard disruption. The study emphasises that without these system conditions in place, exiting children from sexual exploitation becomes significantly more difficult.

McKibbin, G., Humphreys, C., Sastre Gomez, L. V., Bloxsom, G., & Dixson, S. (2026). *Disrupting child sexual exploitation: A cautionary tale*. **Child & Family Social Work, Advance online publication**. https://doi.org/10.1111/cfs.70120

Relationship between poverty and child abuse and neglect

Child safety | Poverty

This systematic review synthesises international quantitative evidence on the relationship between **individual and family-level poverty** and **child maltreatment**, highlighting where associations are consistently reported and where evidence is reported only in aggregate form. The study included 24 peer-reviewed quantitative studies between 2016 and 2023, conducted across Australia (3 studies), Canada (3 studies), the United States (15 studies), Japan (2 studies) and Germany (1 study).

Findings

- All 24 studies included quantitative studies consistently demonstrated a **signification association** between individual or family-level poverty and child abuse and neglect
- **Magnitude of association varies but is often substantial:**
    - Some studies reported large effect size, including elevated odds rations and hazard ratios for maltreatment among children experiencing economic disadvantage.
    - One Australian study estimated that 27% of maltreatment cases were attributable to economic factors.
- Some poverty measures were examined in relation to specific maltreatment subtypes (e.g. neglect, physical abuse, sexual abuse, exposure to domestic violence).
- Other measures, particularly housing instability and duration of exposure to poverty-related programs, were reported only in relation to overall child maltreatment or child protective services (CPS) involvement, without subtype disaggregation.

Evidence matrix

- ✓ indicates that at least one included study reported an association for that pairing
  Highlighted rows have five or more associations
- **-** indicate that no association was reported in the review for that pairing - not evidence of 'no relationship'
- Maltreatment (overall / composite) is used only where studies reported aggregated outcomes (e.g. maltreatment reports, substantiated maltreatment, CPS involvement) without specifying maltreatment type.

Form of poverty measured (as reported)	Neglect	Physical abuse	Emotional / psychological abuse	Sexual abuse	Exposure to DV / IPV	Maltreatment (overall / composite)
Low income (incl. low household income)	✓	✓	✓	_	_	✓
Income-to-needs ratio	✓	_	_	_	_	_
Welfare receipt / public assistance	✓	✓	_	✓	✓	✓
Food insecurity / food neglect	✓	✓	✓	✓	✓	_
Housing instability / homelessness	_	_	_	_	✓	✓
Household overcrowding	_	_	_	✓	_	_
Economic hardship (basic needs unmet)	✓	✓	✓	_	✓	✓
Financial instability (e.g. unable to pay utilities)	✓	✓	✓	_	_	✓
Duration or persistence of poverty	_	_	_	_	_	✓
Multidimensional socioeconomic disadvantage	✓	✓	✓	✓	✓	✓

Skinner, G. C. M., Hodges, N., & Kennedy, E. (2026). A systematic review of the relationship between poverty and child abuse and neglect: Evidence from individual and family level studies. Children and Youth Services Review, 182, 108753. https://doi.org/10.1016/j.childyouth.2026.108753

Parent and child factors associated with child abuse potential in families with toddlers

Child safety | Family support services

Research on child abuse potential has largely relied on parent self-report measures, which may miss important behavioural and relational risk factors. This study addresses a critical gap by examining how observed parent-child interactions, alongside parent-reported factors, relate to child abuse potential, including among parents who produce invalid profiles on screening tools and are often excluded from analysis.

The current study

- Study examined parent- and child-level factors associated with child abuse potential in families with toddlers (aged 14–24 months).
- Used a multi-method approach, combining parent self-report measures and direct observation of parent-child interactions.
- Parent emotion dysregulation was the only significant predictor among parents with valid screening profiles.
- When parents with invalid screening profiles were included, additional predictors emerged: parenting stress; romantic attachment avoidance; observed negative physical touch
- Observed child behaviours were ***not*** associated with child abuse potential in either analysis.

Implications

- Excluding parents with invalid BCAP (Brief Child Abuse Potential Inventory) profiles may result in **high-risk families being overlooked**.
- Parent-level factors appear more salient than child behavioural characteristics in understanding child abuse potential in families with toddlers.
- Early identification of parent emotion dysregulation, stress, and relational difficulties may support **preventive intervention** before abuse occurs.

Druskin, L. R., Phillips, S. T., Kohlhoff, J., Owen, C. K., Han, R. C., Franzese, S. N., Wallace, N., Cibralic, S., Morgan, S., & McNeil, C. B. (2026). *A multi-method evaluation of parent and child factors associated with child abuse potential across valid and invalid profiles on the Brief Child Abuse Potential Inventory*. Infant Mental Health Journal, 47, e70045. https://doi.org/10.1002/imhj.70045

‘Mob want to see mob’: Aboriginal and Torres Strait Islander young peoples’ perspectives on accessing primary health care in urban southeast Queensland

Youth mental health

This qualitative study explored enablers and barriers to accessing primary health care (PHC) from the perspectives of Aboriginal and Torres Strait Islander young people aged 15–24 years living in urban southeast Queensland. Using research yarns and yarning groups with 35 participants, findings were analysed thematically and organised using a modified social ecological model.

Key insights

- Health literacy influenced young people’s confidence and ability to recognise health needs and navigate PHC services.
- Family and friends played a key role in providing support, advice and assistance to access care, but reliance on family could also limit access.
- Culturally safe, accessible and holistic PHC services were more likely to engage young people; barriers included cost, transport, appointment availability and opening hours.
- Healthcare providers mattered: trust, respect, confidentiality and feeling listened to shaped young people’s experiences, with many **preferring Aboriginal PHC services**.

Implications

- Young people’s access to primary healthcare is shaped by individual and family factors, but severely restricted by broader structural barriers and urban "medical deserts" (e.g., cost, transport, and resourcing).
- Australia lacks a funded national adolescent health strategy, making it difficult for services to implement international youth-friendly standards.
- Delivering culturally safe services that reflect Aboriginal and Torres Strait Islander young people’s perspectives requires urgent investment in Aboriginal healthcare models and specialized workforce training.

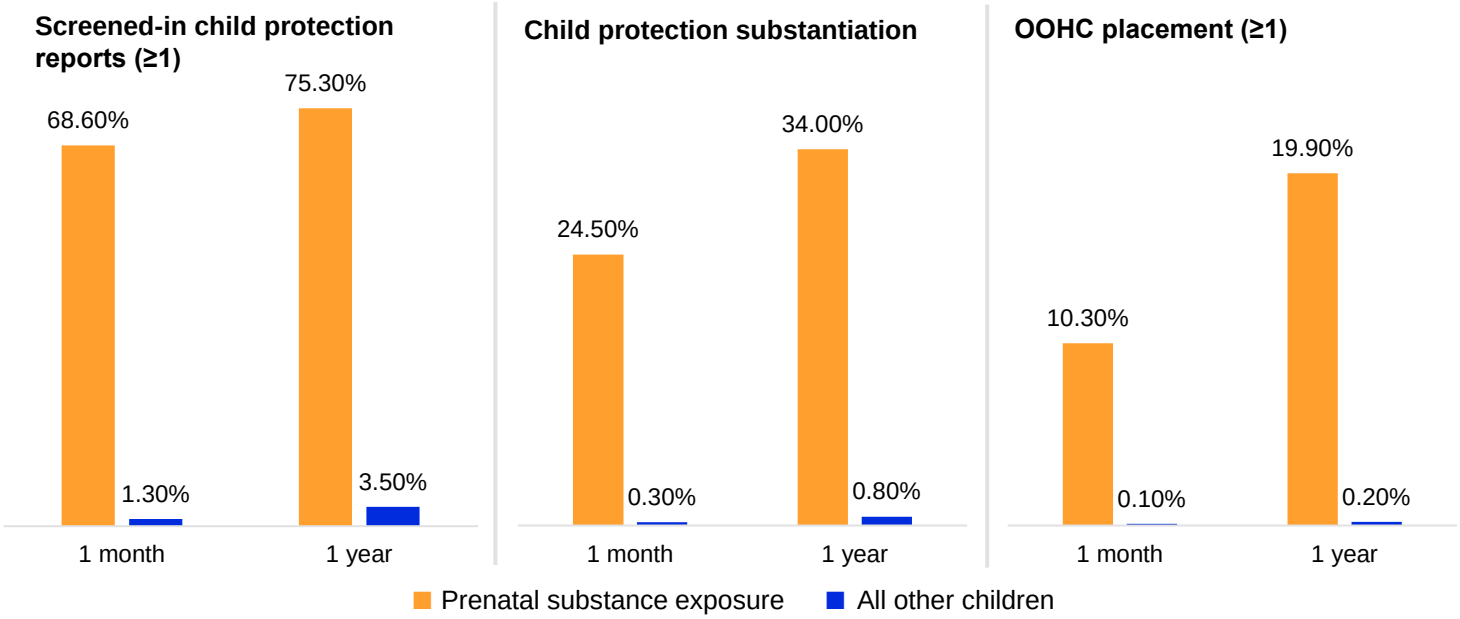
Harfield, S., Dean, J. A., Azzopardi, P., Mishra, G. D., & Ward, J. (2025). ‘Mob want to see mob’: Aboriginal and Torres Strait Islander young peoples’ perspectives on accessing primary health care services in urban southeast Queensland. Australian and New Zealand Journal of Public Health, 49(6). https://doi.org/10.1016/j.anzjph.2025.100273

Prenatal substance exposure and child protection involvement to age 12 years

Child safety | Family support services

This whole-population cohort study followed 1.16 million children born in NSW (2007–2018) to quantify the risk and timing of child protection system involvement among children with prenatal substance exposure compared with all other children. Outcomes included screened-in reports, investigations, substantiations, and entry to out-of-home care (OOHC) from birth to age 12 years.

Results of the 2018 birth cohort



The figure presents cumulative risks of child protection involvement among children born in **2018**, comparing those with prenatal substance exposure to all other children, at 1 month and 1 year of age.

- **Screened-in child protection reports (≥1):** By 1 month of age, 68.6% of children with prenatal substance exposure had at least one screened-in report, increasing to 75.3% by 1 year.
  In contrast, the cumulative risk among all other children was 1.3% at 1 month and 3.5% at 1 year.
- **Child protection substantiations (≥1):** Among children with prenatal substance exposure, cumulative substantiation risk was 24.5% by 1 month and rose to 34.0% by 1 year.
  Corresponding risks for all other children were 0.3% at 1 month and 0.8% at 1 year.
- **Out-of-home care (OOHC) placement (≥1):** By 1 month, 10.3% of children with prenatal substance exposure had entered OOHC, increasing to 19.9% by 1 year.
  For all other children, OOHC entry remained low at 0.1% by 1 month and 0.2% by 1 year.

Brief summary of results from 2007 birth cohort

The study also reports outcomes for a **2007 birth cohort**, followed from birth to **12-years-of-age**, to examine longer-term patterns of child protection involvement.
For children with parental substance exposure in the 2007 cohort, by age 12:

- approximately 90% had experienced at least one screened-in report
- 61% had at least one substantiation
- 39% had experienced one or more OOHC placements.

Compared with 18%, 5%, and 1% of all other children.

Conclusion

The findings show that child protection involvement among children with prenatal substance exposure is evident by one month of age and increases substantially by one year. Initial reports provide an early juncture at which non-stigmatizing antenatal and substance use supports could be activated to reduce progression to more intensive interventions.

Powell, J., et al. (2025). *Prenatal substance exposure and child protection system involvement from birth to age 12 years*. **Paediatrics**. Advance online publication. https://doi.org/10.1542/peds.2024-070444

‘A wicked issue’: Reunification and cumulative risk in child protection

Child safety | Family support services

This chapter critically examines reunification within Australian child protection systems, arguing that while reunification is legislatively prioritised, it remains inconsistently structured and insufficiently resourced in practice.

The author frames reunification as a “wicked issue” due to its complexity, involving intersecting legal, developmental, relational, and systemic factors that resist simple or linear solutions.

The chapter contends that without structured, trauma-informed, and sustained intervention across assessment, therapy, and post-reunification monitoring phases, reunification may replicate instability rather than resolve it.

Core argument: Cumulative harm and system contradictions

- Removal frequently follows chronic and intersecting adversities rather than isolated events.
- Cumulative harm reflects persistent low-level neglect and instability with compounding developmental effects.
- Reunification failure contributes additional trauma through repeated separation and system cycling.
- Australian jurisdictions lack a nationally consistent, evidence-based reunification model.
- The post-reunification period (particularly 12–24 months) carries elevated risk of re-entry.

Joan’s Reunification Services Plan (Illustrative case example)

The chapter presents “Joan” as a case example to illustrate the proposed reunification model.

Joan’s circumstances include:

- history of domestic violence exposure
- substance misuse
- housing instability
- children exposed to trauma and placement disruption.

The figure below illustrates how the model would operate.

1. Reunification Intervention
(Stabilisation and Capacity Building)

- Driver’s licence acquisition
- Car seat installation
- 3× weekly supervised contact
- Domestic & Family Violence Program (Safe & Together + counselling)
- Ongoing Drug & Alcohol Rehabilitation
- Home set-up and resourcing
- Parent coaching & psychoeducation

2. Reunification Therapy
(Relational & Trauma Repair)

- Child-centred play therapy
- Theraplay (attachment repair)
- Filial therapy (caregiver-led therapeutic play)

3. Post-Reunification Services
(Sustained Monitoring & Coordination)

- Ongoing structured support
- Risk monitoring
- Coordinated services
- Attention to re-emergence of prior risks

The vignette illustrates how stabilisation, relational repair, and ongoing oversight operate together within a multi-tiered reunification framework rather than as a single restoration event.

Summary

Evidence shows that failed reunification can have cumulative and long-term consequences for children, particularly where multiple reunification attempts occur or where risks are insufficiently assessed prior to restoration.

The chapter argues that without structured, sustained, and therapeutically informed post-reunification support, reunification risks becoming cyclical and unsustainable.

To address this, it proposes a specialised, NDIS-style model of long-term, flexible, multidisciplinary support that shifts the focus from procedural case closure to developmental repair, relational stability, and enduring family capacity-building.

Collier, E. (2026). A wicked issue: Reunification and its relationship to cumulative risk and harm. In S. India, J. Bryce, & R. Simon (Eds.), *Trauma-Informed and Accumulation-Aware Approaches to Child Protection* (pp. 121–149). https://www.igi-global.com/chapter/a-wicked-issue/401127

Hospital-presenting self-harm and suicide among justice-involved young people on community-based orders

Youth justice | Mental health

This research analyses a longitudinal cohort study of 44,887 justice-involved young people in New South Wales, who were serving community-based orders between 1994 and 2020. The study examines the instances of self-harm and suicide incidence, risk factors, and healthcare contact patterns, to determine the validity of reliance on medical history as a predictor of self-harm and suicide risk for youth justice-involved young people.

Self-harm and suicide incidence

Self-harm:

- A total of 1,901 young people (4.2% of the cohort) experienced a recorded episode of self-harm.
- The overall rate of incidences of self-harm was 11.6 per 1,000 person years, with females being 2.5 times more likely than males to present for self-harm.
- The most common forms of self harm included overdose/poisoning (51.1%) and cutting/sharp object injuries (23.3%).
- The incidence of self-harm peaked sharply at age 13 (27.7 per 1,000 person-years) and generally declined through late adolescence.

Suicide mortality:

- A total of 61 suicide deaths were recorded, translating to 0.4 per 1,000 person years.
- Suicide was responsible for one-third of all deaths in the cohort.
- Unlike self-harm, suicide rates were nearly identical for males and females (0.4 per 1,000 person years).
- Individuals with a prior history of self-harm had a suicide incidence four times higher than those without (1.2, compared to 0.3 per 1,000 person-years respectively

Risk factors

Higher volumes of childhood adversity correlate directly with self-harm rates. Incidence of hospital presentations rose from 6.1 per 1,000 person years for those with exposure to zero adversity types, to 16.7 for those with three or more. Specific factors included:

- **Sexual abuse** – significantly associated for both genders.
- **Emotional abuse** – particularly pronounced for females aged 14-16.

Mental health and neurodevelopmental disorders were also strongly correlated to higher risk of self-harm.

'Hidden' nature of suicide risk

A core finding of the study was the 'hidden' nature of suicide risk among justice-involved young people. The analysis showed that hospital data is an insufficient predictor of suicide fatalities:

- **Pre-offence:** 95.1% of those who died by suicide had no hospital record of self-harm before their first offence.
- **During follow-up:** 75.4% of those who died by suicide had no hospital presentation for self-harm at any point during the study period.
- **Mental health contact:** 63.9% had no recorded hospital presentation for any mental health condition.

For the minority of young people who did present to hospital for self-harm (24.6%), the median time from the last presentation to suicide was only 108 days, presenting a narrow window for intervention.

Policy and practice implications

The study found that justice-involved status is a marker of elevated risk, regardless of a young person's medical history. Recommendations for youth justice systems, and broader healthcare systems include:

- **Universal Screening:** Screening for suicide risk should be mandatory within youth justice settings, rather than being triggered by a history of hospital-presenting self-harm. This includes risk identification at multiple points, including court hearings, pre-sentencing assessments, and community supervision.
- **Developmentally Informed Assessment:** Screening must account for age-varying risks, such as the peak of anxiety-related self-harm in early adolescence and substance-use-related risk in late adolescence.
- **Integrated Case Management:** Effective prevention requires coordinated action across justice, child protection, and health systems to address the high burden of social and environmental adversity. As many suicides occur without prior hospital presentations, assessments should also include 'proximal determinants', including acute interpersonal crisis, intoxication, and unstable living arrangements.

Akpanekpo, E. I., Karystianis, G., Jones, J., & Butler, T. (2026). Hospital-presenting self-harm and suicide among justice-involved adolescents on community-based orders: A population-based cohort study. ***General Hospital Psychiatry***, ***99***, 112–118. https://doi.org/10.1016/j.genhosppsych.2026.01.012