Clinical and Public Health Evaluation of the Care and Protection of Children Legislation Amendment (Every Child Matters) Bill 2026

Australian Medical Association Northern Territory

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Executive Summary

The intersection of statutory child protection, paediatric health, and the social determinants of wellbeing forms one of the most critical and complex domains of public health policy. The Care and Protection of Children Legislation Amendment (Every Child Matters) Bill 2026 (Serial No. 67) proposes systemic reforms to the Northern Territory's child protection framework.[1] Introduced with the stated legislative intent of keeping children safe, ensuring parental accountability, and promoting an early intervention model, the legislation restructures the foundational guiding principles of the Care and Protection of Children Act 2007.[1] The Bill introduces Family Responsibility Agreements (FRAs) and Family Responsibility Orders (FROs), enforces rigid, non-negotiable statutory timelines for family reunification, lowers the threshold for the permanent out-of-home placement of children, and expands worker screening compliance protocols.[1]

A clinical and public health analysis of the proposed legislation, evaluated through evidence-based medical frameworks, reveals divergences between the Bill's statutory mechanisms and established paediatric, psychiatric, and public health best practices. This submission assesses the legislative amendments against peer-reviewed medical literature, epidemiological data regarding the social determinants of health, and the ethical parameters of contemporary medical practice. The analysis indicates that the Bill's heavy reliance on punitive administrative measures, mandatory socioeconomic restrictions (such as compulsory income management and Banned Drinker Orders), and the explicit statutory dilution of the Aboriginal and Torres Strait Islander Child Placement Principle (ACPP) risks significantly exacerbating the very intergenerational trauma, psychiatric morbidity, and paediatric health disparities the legislation ostensibly seeks to mitigate.[3]

By shifting the Northern Territory's child protection system further toward tertiary, statutory escalation rather than primary, health-led community prevention, the legislation fundamentally contradicts the public health approach to child wellbeing.[5] The integration of these child protection measures creates a compounding legislative environment that disproportionately criminalises and pathologises the most vulnerable, predominantly First Nations, paediatric populations in the Territory.[7]

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Table of Contents

The Public Health Framework vs. Statutory Escalation

Child abuse, neglect, and systemic family dysfunction are profoundly linked to the social determinants of health. These determinants encompass poverty, inadequate housing, systemic and historical racism, and untreated parental chronic diseases, including substance dependence and severe mental illness.[9] The medical profession, supported by decades of robust epidemiological evidence, advocates for a public health approach to safeguarding children.[5]

The public health model emphasises a tripartite structure of intervention. Primary prevention involves universal support for all families, such as maternal and child health services, affordable housing, and positive parenting campaigns.[5] Secondary prevention targets vulnerable families with voluntary, early-intervention programs that build skills and address emerging mental health or addiction problems without the threat of state coercion.[5] Tertiary intervention (the statutory child protection system, involving court orders, family policing, and out-of-home care) is universally recognised in medical literature as a measure of absolute last resort, utilised only when alternative non-statutory approaches have failed and imminent harm is present.[5]

The Every Child Matters Bill 2026 fundamentally shifts the Northern Territory's framework away from this evidence-based public health model. While the Explanatory Statement claims to promote an "early intervention model" [1], the primary mechanisms established in the Bill are highly coercive, utilising the threat of tertiary escalation to enforce compliance. The AMA has clearly delineated that policies surrounding housing, employment, and the physical environment exert a profound, measurable impact on health outcomes.[9] Addressing these social determinants is highly cost-effective; for instance, the AMA estimates that adequately addressing the social determinants of health could result in 60,000 fewer hospital admissions annually across Australia, alongside millions of fewer Medicare services, yielding billions in healthcare savings.[9] However, the Bill seeks to modify the behavioural symptoms of poverty and disadvantage through statutory contracts and court orders, rather than addressing the root socio-environmental causes.

Intervention Paradigm	Focus	Medical & Public Health Efficacy	Alignment with Bill 2026
Primary Prevention	Universal community support, maternal health, secure housing, poverty reduction.	High. Prevents the onset of family dysfunction by mitigating the social determinants of health.	Low. The Bill provides no structural socioeconomic support, focusing on parental compliance.
Secondary Prevention	Voluntary clinical intervention, accessible addiction and mental health therapy.	High. Fosters a therapeutic alliance, builds long-term parental capacity.	Low. The Bill relies on coercive, legally binding agreements (FRAs) enforced by the CEO.
Tertiary Intervention	Statutory surveillance, court orders, out-of-home care, child removal.	Low (as a preventative tool). OOHC is associated with severe paediatric trauma and poor lifelong health outcomes.	High. The Bill expands the scope and severity of statutory orders (FROs) and accelerates permanent removal timelines.

Subjecting families to tertiary statutory surveillance without adequate primary and secondary health support increases the allostatic load; the physiological wear and tear on the body caused by chronic stress. This chronic stress damages both parental executive functioning and the physical, psychological and neurological development of the child. A genuine public health approach, as endorsed by the clinical literature, requires decentralised, community-led support services that engage families voluntarily, fostering trust rather than utilising the threat of state sanction.[5]

Cultural Safety and the Aboriginal Child Placement Principle (ACPP)

A central tenet of the Bill is the complete overhaul of Part 1.3 of the Act, which reorders the universal principles, roles, and responsibilities governing child protection.[1] The new Section 8 establishes a rigid, hierarchical matrix of considerations for determining the "best interests of the child," explicitly prioritising physical safety, protection from harm, and stable living arrangements over the child's cultural, spiritual, and family connections.[1]

Simultaneously, the Bill introduces a broad "Placement of children" principle in Section 12B, which applies universally to all children, while amending Section 12C, which pertains exclusively to Aboriginal children.[1] The new Section 12C(4) explicitly dictates that the principles relating to Aboriginal children are entirely subject to the universal placement principles set out in Section 12B.[1] This legislative restructuring effectively dilutes, and in many practical applications dismantles, the Aboriginal and Torres Strait Islander Child Placement Principle (ACPP).

The Medical and Psychiatric Imperative of Cultural Connection

The dilution of the ACPP contradicts established medical, psychiatric, and developmental consensus. The AMA explicitly recognises that cultural determinants play a strong, positive, and protective role in health and wellbeing.[3] Culturally safe practice requires genuine efforts to understand the enduring physiological and sociological impacts of colonisation and systemic racism on health access and outcomes for Aboriginal and Torres Strait Islander patients.[3] For First Nations children, cultural safety is not merely a supplementary administrative benefit; it is a fundamental determinant of mental health, psychological resilience, and healthy neurodevelopmental identity formation.[3]

Peak Indigenous and child welfare organisations, including the Secretariat of National Aboriginal and Islander Child Care (SNAICC) and the Aboriginal Peak Organisations Northern Territory (APO NT), have strongly condemned the Bill. They argue that the legislation deliberately portrays Aboriginal families, communities, and culture as inherent risks to child safety, rather than recognising them as vital protective factors.[4] From a clinical psychiatric perspective, severing a First Nations child from their kinship group, community, and country induces profound developmental trauma. This can result in catastrophic long-term psychiatric, medical, and social outcomes, including exponentially elevated rates of chronic disease, substance dependence, and youth suicide.[3]

The Subordination of the Five Elements of the ACPP

The ACPP is internationally recognised as best practice and comprises five core, interrelated elements: Prevention, Participation, Partnership, Placement, and Connection.[17] The proposed legislation systematically undermines these elements through statutory semantics and

structural subordination:

1. **Placement (Section 12B):** Section 12B(2) removes the strict, legally binding cultural hierarchy for placement that prioritises extended Aboriginal family and community. Instead, it allows children to be placed with "a person approved by the CEO" if placement with a parent or immediate family member is deemed not practicable or consistent with the heavily redefined, race-blind best interests criteria.[1]

2. **Participation and Partnership (Section 12C):** Section 12C(2) revokes the previous statutory *right* of Aboriginal children and their families to participate in administrative or judicial decision-making processes, reducing it to a mere "opportunity to participate".[1] This semantic downgrade strips Indigenous families of legal enforceability. This directly contradicts the AMA's position that Aboriginal people must have a leading, self-determined role in identifying and responding to health and social challenges, and that decision-making should be decentralised to local communities and Aboriginal Community Controlled Health Organisations (ACCHOs).[10]

By subordinating Indigenous cultural rights to a homogenised, race-blind standard of "safety," the Bill ignores the medical reality that systemic racism and the ongoing impacts of colonisation are primary drivers of health inequity.[3] Culturally safe practice requires acknowledging these historical impacts, yet the Bill's framework reflects an assimilationist approach that the medical community has long recognised as highly detrimental to the physiological and psychological health of Indigenous children.[3] The Northern Territory government's assertion that "every child matters regardless of where they come from, their race or religion" [2], while seemingly egalitarian, operates as a mechanism of structural erasure, ignoring the specific, targeted, and culturally grounded interventions required to heal First Nations communities.

Coercive Control: Family Responsibility Agreements and Orders

The insertion of Part 2.1A (Family Responsibility Agreements) and Subdivision 1A (Family Responsibility Orders) represents a expansion of the state's coercive powers over vulnerable families, shifting mechanisms previously housed in the *Youth Justice Act 2005* directly into the child protection framework.[1] Triggered by an "event of concern" (which the Bill broadly defines to include a child exhibiting anti-social behavior, missing school, or experiencing an event that adversely affects their wellbeing) the CEO is mandated to invite parents into a Family Responsibility Agreement (FRA).[1] If a parent refuses to engage, or fails to comply with the stringent conditions of the FRA, the CEO may escalate the matter directly to the Court to secure a Family Responsibility Order (FRO).[1]

Section 102E dictates the potential contents of an FRO, granting the Court sweeping authority over the daily lives of families. The Court can direct parents to undertake counseling, attend

personal development courses, control the child's whereabouts (including forbidding contact with specific individuals or places), and force the child to attend medical and health appointments.[1] More alarmingly from a public health perspective, Section 102E(1)(c) permits the Court to direct the CEO to subject the parent to specific, highly punitive socioeconomic interventions. These include:

- Giving notice to the Commonwealth Secretary to subject the parent to the enhanced income management regime under the *Social Security (Administration) Act 1999 (Cth)*.
- Making an application for a Banned Drinker Order (BDO) under the *Alcohol Harm Reduction Act 2017*.
- Providing information to housing authorities for the purpose of imposing an acceptable behavior agreement, or applying to have the family's residence declared a restricted premises under the *Liquor Act 2019*.[1]

The Clinical Inefficacy and Harm of Income Management

The integration of compulsory income management into child protection orders runs counter to a vast body of public health evidence. Income management policies quarantine a significant portion of a recipient's welfare payments, restricting their use to specific essential goods and services, ostensibly to ensure funds are spent on child welfare rather than alcohol, gambling, or illicit substances.[15]

However, the AMA has consistently highlighted that substance dependence and behavioural addictions are chronic brain diseases, not moral failings that can be cured by punitive financial restriction.[14] Compulsory income management has operated in the Northern Territory since 2007, and extensive, peer-reviewed evaluations have failed to demonstrate any systematic, community-level improvements in health, education, crime reduction, or child wellbeing that can be attributed to the policy.[16]

Crucially, empirical studies assessing the causal impact of income management on specific child health metrics have revealed negative outcomes. Research evaluating birth outcomes in the Northern Territory found that exposure to income management did not improve infant health, and by extension, failed to produce the desired positive changes in household consumption patterns.[19] More concerningly, the data indicated that exposure to income management, particularly in the first or second trimester of pregnancy, was associated with lower average birth weights and a significantly higher probability of low birth weight (less than 2500g). This is a critical, universally recognised predictor of lifelong chronic illness, impaired cognitive development, and premature mortality.[19]

The financial anxiety, loss of autonomy, and abrupt "income shock" associated with compulsory income management generate psychological distress, which translates physiologically into adverse perinatal and paediatric health outcomes.[18] Subjecting a vulnerable parent to income management via a Family Responsibility Order [1] is therefore likely to deteriorate, rather than

safeguard, the physiological health and safety of the child.

Banned Drinker Orders and the Medical Model of Substance Dependence

The AMA NT supports evidence-based alcohol supply reduction measures to combat the Territory's uniquely high rates of alcohol-related morbidity and mortality.[20] The AMA NT has supported the Banned Drinker Register (BDR) as a necessary population-level supply reduction tool.[21] However, the efficacy of the BDR is severely compromised without complementary demand-reduction strategies, such as the Minimum Unit Price (MUP) for alcohol, a vital public health policy that the current NT Government recently scrapped, against the strong advice of the AMA NT and the Menzies School of Health Research.[20]

Utilising a Banned Drinker Order as a punitive, coercive mechanism within a statutory child protection framework fundamentally misunderstands the clinical pathology of addiction.[22] Substance dependence involves complex, long-term neurobiological adaptations.[14] Directing a parent onto the BDR or forcing them into mandatory counseling via a court-mandated FRO [1] constitutes coercive medical treatment.

A comprehensive review of international and Australian literature indicates that compulsory or coercive addiction treatment is broadly ineffective. Coercive methods are generally less successful than voluntary methods at promoting long-term abstinence and reducing criminal recidivism, and can, in some instances, actively increase post-treatment drug use and harm.[23]

Treatment Modality	Definition / Referral Source	Clinical Outcomes	Ethical / Public Health Implications
Voluntary Treatment	Self-directed engagement with health services, community support.	High long-term efficacy. Sustained behavioural change.	Upholds patient autonomy. Reduces stigma. Highly recommended by the AMA.

Involuntary Treatment	Medical commitment to prevent imminent physical harm (e.g., severe withdrawal).	Reduces immediate acute harm. Short-term stabilisation.	Necessary in acute crises but insufficient for long-term behavioural addiction recovery.
Coercive Treatment (FROs)	Mandated by justice, child protection, or regulatory bodies under threat of sanction.	Poor long-term efficacy. High relapse rates. May increase harm and recidivism.	Ethically fraught. Fractures the therapeutic alliance. Drives vulnerable populations away from care.

The AMA asserts that individuals experiencing substance dependence must be treated with the same clinical dignity and access to care as patients with any other serious medical condition, emphasising that evidence-based, adequately resourced, voluntary treatment yields the superior clinical outcomes.[14] By entangling statutory child protection with punitive substance control mechanisms, the legislation actively discourages parents from seeking medical help for their addictions. The fear of statutory repercussions acts as a massive deterrent to healthcare access, driving highly vulnerable populations into the shadows and away from the medical support they desperately require.[24]

Statutory Timeframes, Permanency, and the Pathology of Trauma

The Bill seeks to expedite permanency for children interacting with the child protection system. Section 12D introduces a strict "proactive efforts" framework, mandating that the CEO must make reasonable efforts to reunify a child with their parents within a rigid two-year window following removal. The legislation stipulates that intense efforts must be focused within the first six months of this period.[1] Concurrently, amendments to Section 128 dictate that the Court may issue a maximum of two short-term parental responsibility directions (limited to one year each). A second short-term order is only permissible if the Court is satisfied there is a "high probability" of reunification that will not adversely affect the child's long-term stability.[1]

While the overarching goal of minimising placement instability and "drift" in out-of-home care (OOHC) is a valid concern given that children in OOHC experience severe physical, cognitive,

and mental health trauma, the imposition of an inflexible, two-year statutory clock is clinically unsound when applied to families facing profound, complex, and compounded trauma.[7]

The Clinical Timeline of Recovery

Healing from severe psychiatric conditions, chronic substance dependence, and the deep neurological impacts of intergenerational trauma does not follow a linear, legislatively mandated schedule. Addiction recovery, for instance, frequently involves periods of relapse, which are clinically recognised by addiction medicine specialists and psychiatrists as an expected part of the chronic disease pathology, rather than a failure of moral character or parental love.[14]

By capping short-term orders at a strict maximum of two years and lowering the threshold for permanent removal, the Bill virtually guarantees that parents who require longer-term therapeutic interventions will permanently lose their children. This rigid framework disproportionately impacts First Nations families living in remote and regional areas of the Northern Territory. These families face profound systemic barriers to accessing timely healthcare, extended waiting lists for culturally safe residential rehabilitation programmes, and critical, systemic public housing shortages.[26] A parent may demonstrate profound, genuine commitment to medical recovery but fail to meet the state's arbitrary two-year deadline simply because a residential rehabilitation bed or appropriate public housing was structurally unavailable. Punishing a parent for the structural deficits of the state's health and housing systems is a profound failure of public policy.

The Trauma of Permanent Severance

When a child is permanently removed under a long-term parental responsibility direction or a permanent care order, the psychological trauma inflicted is enduring and often irreversible. The AMA recognises that maintaining family ties is crucial for healthy paediatric development.[10] The Bill's emphasis on rapid "permanency" often translates, in practical reality, to placing children outside their kinship networks, particularly given the concurrent legislative weakening of the ACPP.[1]

Medical literature confirms that children placed in stable, out-of-home care outside their culture still suffer from severe identity disruption, elevated rates of psychological distress, and profound feelings of alienation.[28] True developmental permanency and secure attachment are best achieved by prioritising extensive, long-term, well-resourced support for the biological family and kinship network, regardless of arbitrary statutory timelines.[28]

The Youth Justice Nexus, MACR, and Fetal Alcohol Spectrum Disorders (FASD)

The Every Child Matters Bill cannot be analysed in clinical isolation from the broader, punitive legislative environment currently being constructed in the Northern Territory. The Bill dangerously intertwines the child protection system with the youth justice system. Section

65D(6) defines an "event of concern" that triggers a Family Responsibility Agreement to explicitly include a child exhibiting criminal or anti-social behavior.[1] Furthermore, Section 65E creates a direct pipeline between law enforcement and child protection, enabling police officers to make direct referrals to the child protection CEO when a child is found not criminally responsible due to age (*doli incapax*).[1]

This is alarming given that the Northern Territory Government recently passed legislation reversing progressive reforms, lowering the minimum age of criminal responsibility (MACR) from 12 back to 10 years old.[8] The AMA, in conjunction with the Law Council of Australia, the Royal Australasian College of Physicians, and the National Children's Commissioner, has unequivocally stated that the MACR should be raised to 14 years across all Australian jurisdictions.[7] Robust neurological and paediatric evidence demonstrates that children under 14 lack the executive functioning, impulse control, and consequential reasoning necessary for criminal culpability.[7]

The Pathology of "Crossover Kids"

The Sentencing Advisory Council's documentation of "Crossover Kids" (vulnerable children who transition directly from the child protection/OOHC system into the youth justice system) highlights a catastrophic failure of public policy.[7] Children in the child protection system have almost universally experienced physical, emotional, or neurological trauma.[7] When these traumatised children exhibit behavioural dysregulation (a clinical, neurobiological symptom of complex trauma) the Bill's framework categorises this as an "event of concern" or "anti-social behaviour," triggering coercive FRAs or FROs for their parents.[1]

Because the NT has lowered the age of criminal responsibility to 10, a prepubescent child experiencing extreme distress due to family dysfunction or systemic neglect is now highly vulnerable to both police intervention and child protection coercion.[8] The AMA asserts that criminalising the behaviour of young, traumatised children creates a vicious cycle of disadvantage, increasing the likelihood of lifelong interaction with the penal system.[29] Expanding the purview of child protection authorities to act as an extension of the penal system, through police referrals for children deemed *doli incapax*, further criminalises social vulnerability.

The Under-Diagnosed Crisis of FASD

This youth justice nexus is particularly devastating when considering the prevalence of Fetal Alcohol Spectrum Disorders (FASD) in the Northern Territory. FASD is a severe neurodevelopmental impairment caused by prenatal alcohol exposure. Data indicates that in some high-risk Indigenous communities, FASD prevalence may be as high as 12 percent, with broader data suggesting up to 37 percent of children in the Northern Territory are considered developmentally vulnerable.[31] Furthermore, estimates suggest that 60 percent of adolescents with a FASD have been in contact with the criminal justice system.[30]

Children with FASD suffer from profound deficits in impulse control, inappropriate reactions to

stimuli, and a severe inability to understand cause and effect or obey complex court orders.[30] Holding a 10-year-old with undiagnosed FASD criminally responsible for anti-social behaviour, and subsequently punishing their parents with a Family Responsibility Order for failing to control that neurobiologically driven behaviour, represents a profound failure of both medical understanding and legislative morality.

Impacts on the Healthcare System and Medical Ethics

The proposed legislation places medical practitioners in an ethically fraught position and threatens the foundational doctor-patient relationship, which relies entirely on mutual trust, confidentiality, and voluntary engagement. The AMA Code of Medical Ethics strictly dictates that physicians must act in the best interests of their patients, maintain strict confidentiality, and protect patient autonomy against external coercion.[32]

The Weaponisation of Medical Data and Care

Under the provisions of the Bill, FRAs and FROs can legally mandate that children attend medical appointments, and that parents undertake specific therapeutic counseling or rehabilitation programs.[1] Furthermore, the CEO's expanded investigative powers (Section 32) allow for intrusive inquiries specifically to assess compliance with these family responsibility orders.[1]

When medical attendance is mandated by a statutory order backed by the explicit threat of child removal or financial penalisation, the clinical environment is fundamentally and destructively altered. Patients may view healthcare providers not as therapeutic allies bound by confidentiality, but as agents of the government tasked with monitoring compliance and reporting failures.[25] This perception destroys trust, which is the cornerstone of effective healthcare delivery.[25] If a mother knows that disclosing her struggles with alcohol dependence, domestic violence, or psychological distress to her doctor might be subpoenaed or used by the CEO to enforce an FRO or initiate a permanent care order, she will actively avoid seeking medical help until a catastrophic crisis occurs.[25]

Mandatory reporting laws already create significant tension in the therapeutic relationship; physicians must constantly balance the immediate safety of the child with the risk of discouraging parents from accessing care.[25] The Every Child Matters Bill exacerbates this tension by creating a highly punitive continuum of care. The medical profession strongly opposes frameworks where clinical care is co-opted for coercive control, as it violates the core tenets of medical ethics and patient autonomy.[33]

The Economic Burden on an Over-Stretched Health System

The Northern Territory healthcare system is already strained to the breaking point by the high burden of chronic disease, vast geographic and logistical challenges, and workforce shortages.[18] The costs associated with treating the downstream, tertiary effects of social neglect are astronomical.[27] For example, the AMA NT has previously highlighted that the health

system costs for treating remote patients in the NT are exponentially higher than those in urban centers; treating a specific condition may cost $638 in metropolitan NSW, but cost $38,364 to achieve the same health outcome in remote Arnhem Land.[27]

By failing to invest in primary prevention and instead relying on the expensive, tertiary statutory removal of children and punitive court processes, the NT Government is ensuring a continuous, expensive pipeline of complex health patients. Children removed from their families and placed in OOHC demonstrate significantly higher rates of physical health deficits, undiagnosed developmental delays, and severe mental health disorders.[7] The failure to adequately fund community-based, culturally safe early intervention guarantees that the NT healthcare system will bear the massive long-term financial and clinical burden of this short-sighted legislative approach.[6]

Comprehensive Actionable Recommendations

If the objective of the Every Child Matters Bill 2026 is genuinely to improve the safety, health, and wellbeing of children in the Northern Territory, the legislation must be fundamentally changed and realigned with evidence-based public health principles. Relying on extensive medical literature and established AMA policy positions, the following structural requirements are essential for effective child protection reform:

1. Re-establishing the Primacy of Cultural Safety and the ACPP

Safety and cultural connection are not mutually exclusive concepts to be ranked in a statutory hierarchy; they are inextricably linked determinants of health. Section 8 and Section 12C of the Bill must be amended to fully embed the Aboriginal and Torres Strait Islander Child Placement Principle to the standard of "active efforts" in legislation, ensuring it is not subordinated to generalised placement principles.[34] Culturally safe care is a clinical necessity, not a supplementary ideal.[3] First Nations communities must have legally enforceable rights to participate in decision-making, ensuring that children remain connected to their kinship networks, thereby mitigating the physiological and psychological devastation of cultural dislocation.[12]

2. Transitioning from Coercive Control to Community-Led Support

Family Responsibility Agreements and Orders must be stripped of their punitive, coercive elements. Utilising child protection legislation to enforce income management, Banned Drinker Orders, or restricted premises declarations represents an unethical and clinically ineffective use of state power that will drive families away from healthcare.[13]

Instead of threatening families with financial restriction and child removal, the government must invest heavily in primary prevention and secondary support services. This involves:

- **Empowering ACCHOs:** Shifting funding and decision-making power directly to Aboriginal Community Controlled Health Organisations (ACCHOs), which are empirically proven to deliver culturally safe health outcomes compared to mainstream, state-run

services.[11]

- **Expanding Voluntary Treatment:** Dramatically expanding access to voluntary, evidence-based alcohol and drug rehabilitation programs, including establishing facilities in remote areas so parents are not forced to leave their communities to receive care.[17] The NT Government must also reinstate the Minimum Unit Price (MUP) for alcohol to address the supply-side drivers of addiction.[20]
- **Addressing Social Determinants:** Implementing cross-portfolio policies that guarantee secure housing, food security, and access to education, which are the true, foundational elements of child safety and public health.[9]

3. Decriminalising Vulnerability and Extending Therapeutic Timelines

The deliberate intersection of the child protection system with the youth justice system must be severed. The Northern Territory must urgently heed medical consensus and raise the minimum age of criminal responsibility to 14 years.[7] Behavioural dysregulation in traumatised ten-year-olds, many of whom suffer from undiagnosed FASD, must be treated as a paediatric and psychological health crisis requiring intensive therapeutic intervention, not as a criminal or statutory "event of concern" warranting police referral or parental penalisation.[1]

Furthermore, the rigid two-year statutory clock for reunification and the limitation on short-term protection orders must be revised. While children need stability, permanency should not be weaponised to prematurely sever biological family ties due to structural health system delays.[28] Clinical recovery from addiction and complex trauma requires flexible, individualised timelines.[14] The legislative framework must allow for ongoing, long-term support for family preservation, recognising that healing is a non-linear medical process.

Conclusions

The Care and Protection of Children Legislation Amendment (Every Child Matters) Bill 2026 presents a concerning, regressive shift in Northern Territory social and health policy. Evaluated through the lens of medical science, public health ethics, and robust epidemiological data, the Bill's reliance on statutory coercion, the overt dilution of cultural safety protections, and the imposition of rigid timelines fundamentally undermine its stated objective of child protection.

Child abuse, neglect, and family dysfunction are severe manifestations of systemic failures: entrenched poverty, intergenerational trauma, the lack of secure housing, and untreated chronic illnesses such as substance dependence. The medical evidence is unequivocal: punishing the symptoms of these systemic failures through coercive state interventions like directed income management, forced medical compliance, and the permanent removal of children from their cultural heritage exacerbates psychological trauma and physiological disease.

For a child protection framework to succeed, it must be deeply rooted in a public health

approach that prioritises primary prevention, addresses the socioeconomic determinants of health, and empowers community-led, culturally safe healthcare models. The legislation in its current form threatens to drive highly vulnerable families away from essential medical and support services, deepen the stark health disparities faced by First Nations communities, and perpetuate a cycle of trauma and criminalisation that will heavily burden the Northern Territory's healthcare and justice systems for generations. Comprehensive amendments, guided by clinical evidence, medical ethics, and human rights principles, are absolutely imperative before this legislation progresses.

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