Australian Medical Association NT

Madam CHAIR: On behalf of the committee, I welcome everyone to this public hearing into the Care and Protection of Children Legislation Amendment (Every Child Matters) Bill 2026.

I welcome to the table to give evidence to the committee representatives from the Australian Medical Association Northern Territory, Dr John Zorbas and Dr Rosie Rock. Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and I look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. This is a public hearing and is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask the committee to go into a closed session and take your evidence in private.

Could you please each state your name and the capacity in which you are appearing.

Dr ZORBAS: Dr John Zorbas, I am here as President of the Australian Medical Association of the Northern Territory. I work as an intensive care specialist and emergency physician in the Territory for NT Health, and I am not representing NT Health in that capacity today.

Dr ROCK: Dr Rosie Rock, I am here in the capacity of a councillor of the Australian Medical Association. I also work at NT Health as a paediatrician, but I am not representing NT Health today.

Madam CHAIR: Dr Zorbas, would you like to make any opening statements?

Dr ZORBAS: Thank you for inviting us to provide our testimony to this committee for the care and protection of children legislation amendment. I commend our report to the council in our public submission and would like to provide a brief summary of some of those elements, then pass to Dr Rosie Rock to talk briefly on childhood development and the interplay between that and this Bill.

We come from a place of public health. That is where doctors work and indeed that is where we treat our patients. The difference between most of the amendments in this legislation and how we look at things through a public health lens is where we sit on a spectrum from primary intervention to tertiary intervention. Much of the emphasis in this Bill is on tertiary intervention such as court orders, family responsibility orders and arrangements, whereas primary prevention sits in the space of childhood health or access to child health resourcing, safe housing, perinatal health resources et cetera.

Through the lens of public health, tertiary prevention is the last resort for a system that is at risk of absolute immediate harm. The AMA position is that fixing social determinants would be a more effective measure at improving childcare and protection in the Northern Territory. Our position statement on social determinants of health suggests that by correcting these determinants we can avoid 60,000 admissions to hospital and millions of Medicare services. Put simply, you cannot fix poverty with court orders.

Much has been made of the cultural safety elements of this Bill in the media, and I would like to start by pointing out that roughly 90% of children in the out-of-home care system are of Aboriginal and Torres Strait Islander descent. If I can use a metaphor examining how we deal with road safety, when we look at road safety and we have a limited budget, if we have a particular type of intersection that is in need of repair and that intersection made up 90% of our road system we would have no issue dedicating 90% of the resources to that system or building a system around the needs of that particular type of intersection. We would not accuse the local council of bias against other roads.

Cultural safety is not something that needs to sit below any element of safety. Cultural safety can sit alongside all other elements of safety. It is a primacy of safety with Aboriginal and Torres Strait Islander communities. When done well, cultural safety protective factors outperform, but they do need genuine efforts. It is just as poot to pay lip-service to elements of cultural safety and use them as a tick-box exercise.

Severing kinship induces developmental trauma. It is not mutually exclusive for us to deal with cultural safety as separate from all other forms of safety, in particular, participation of the family. These amendments remove the legal right of the family and give them an opportunity to participate in proceedings. We would argue that the onus is on the government; the burden of proof lies with the government to justify the removal of family

from a situation as opposed to the other way around. That is not to say that there is never a situation in which this might need to occur; however, it is where the burden or proof lies.

In terms of coercive control, again there is a lot of emphasis on tertiary measures, and we have moved directly to tertiary measures in a lot of areas within this Bill without paying the same attention to primary preventive measures.

We have had income management systems in the Northern Territory since 2007, and we have not seen them fix the majority of health impacts that we deal with on a daily basis in our system.

On substance use disorders, which do interplay with this Bill, we know that mandatory treatment is broadly ineffective in all forms. The AMA has supported supply reduction measures such as the Banned Drinker Register, but they must be done in concert with demand reduction measures such as a minimum unit price for alcohol, which we also strongly support. The entanglement of justice and health dissuades voluntary treatment and stops people from coming to us at a time when they need us the most.

The interplay with youth justice cannot be ignored either. This is not a single piece of legislation that sits in isolation of all others that have been passed in the field of youth justice. We are at risk of creating a pipeline of crossover kids where kids leave the out-of-home care system and enter immediately the youth justice system if they are not there already.

Previously we have argued that the minimum age of criminal responsibility should be 14 not 10, and supporting us on that is the Legal Council of Australia, the Royal Australian College of Physicians and the national child commissioner. I recognise that is not the subject of this Bill today, however. Children under the age of 14 lack executive functioning, they lack impulse control and consequential reasoning necessary from criminal culpability.

There is an overwhelming amount of undiagnosed foetal alcohol spectrum disorder in the Territory which also impairs executive functioning and impulse control. In that context it should be noted that we only have eight detox beds in the Territory and zero government-supported rehab beds. To think that we can deal with problems such as this without a concomitant increase in resources to alcohol and other drugs resources I think is folly. There is a huge overlap between substance use disorders, parenting and the way children are raised in the Territory.

In terms of impact on healthcare we are no longer therapeutic allies but agents of government when mandatory treatment orders are in place. This means people will avoid medical help, leading to greater harm down the track because we know that you cannot ignore issues; they only get worse.

We are also at a point where all of us here have publicly argued for the lack of resourcing in our hospital system, especially at a federal level. Primary prevention saves us inordinate amounts of money down the track, and we cannot afford to only deal with the expensive end of hospital care with the ambulance at the bottom of the cliff.

In terms of the recommendations we make in this submission, broadly they are three:

1. The re-establishment of the primacy of cultural safety, alongside physical safety, secure housing et cetera and other determinants of health.

2. A higher emphasis on measures that sit at the top of the cliff not at the bottom of the cliff. Empowering community-controlled organisations such as ACCHOs, rapid expansion and resourcing of voluntary treatment systems, and addressing the social determinants of health in the Northern Territory.

3. Decriminalising vulnerability and extending therapeutic timelines.

I now pass to my colleague Dr Rosie Rock to expand on childhood development and the interplay between that and this Bill.

Dr ROCK: In addition to what John said, I would like to emphasise the importance of the first period of a child's life and their brain development which continues throughout that time from conception all the way through the first 1,000 days, and even on until their mid-twenties their brain will be developing. This time is essential that bonding and that care is provided to children. The opportunity to form those bonds with not just the primary caregivers but extended family and kinship groups is essential, and it must be prioritised within this Bill.

We have an incredibly challenged population. I deal firsthand with families who are in contact with the child protection system and families who have been through the child protection system and reunified with their kids, and it is not an easy thing for families and children to go through.

I witness the consequence of out-of-home care every day in my work, and I see the harms that this brings to children. Removal of children is not something that we can take lightly. When it does need to occur, it needs to occur with the utmost respect for the child and their needs.

The timeframes proposed in this Bill and early switching to permanency as a priority is against that desire for children to know who they are and their identity that they need to understand to become an adult who can process the challenges that they have faced in their early years. The timeframes proposed, of rapid transition to long-term care, in this Bill are absolutely at odds with what we experience every day in our workplace. We have limited access to drug and alcohol supports. We have limited access to domestic violence support for families in crisis. There are often extended wait times for six or 12 months for people to be able to access some of these services. For that reason alone, without providing the supports for families as a first measure and that primary intervention, we will not see the benefits that we can in changing the outcome for these kids.

Mr YOUNG: Thank you, Dr Zorbas and Dr Rock, for appearing before us and your submission and the time taken to put that in.

In your submission—you just touched on it—you spoke about the trauma of permanent severance from family. You also stated the psychological trauma inflicted on children is enduring and often irreversible. In my opinion, this is evidenced in the number of coronial inquest reports of children who have died while in the care of the DCF (Department of Children and Families). Can you provide the committee a deeper understanding of how the draft Bill may cause further harm to vulnerable children rather than prevent?

Dr ZORBAS: Our overarching fork in the road is the lack of emphasis on primary prevention measures. It is far more expensive and harmful to deal with these issues at the end of the road rather than at the start of them, leading children to enter a system in which they come to repeat subsequent harm. It is not single episodes of harm; it is multiple, predictable repeat episodes of harm. The best victory and outcome would be to prevent entering the system at the very start. To think that we can do that in every case is not realistic and is unachievable.

To answer your question, we would want to see a greater emphasis on primary prevention of children needing to enter care systems rather than tertiary prevention.

Dr ROCK: In addition to what John said, I add that whilst there is safety mentioned as the priority for placement of these children, the realistic experience is that the number of children I see have had multiple carers and case workers with a frequent revolving door of sometimes up to 10 different case workers for a year, so the experience of attachment for these kids is completely ruptured. That is harmful and that is where this harm begins.

Attachment is essential for us in any of our relationships. It is foundational for our future relationships in our lives. To understand, that care and support we experience in those early years, knowing who we can trust and that the adults in our lives are looking out for our best interests, is absolutely critical. I do not think we have that guaranteed within this.

Mr YOUNG: In your submission you also stated that the primary mechanisms established in the Bill are highly coercive, utilising the threat of tertiary escalation to enforce compliance. You went on to say that using the banned drinker order as a punitive, coercive mechanism within a statutory child protection framework fundamentally misunderstands the clinical pathology of addiction. How can the government better work with families to ensure that children are safe?

Dr ROCK: I would suggest that drug and alcohol addiction are a symptom of dysfunction primarily and a legislated punitive measure will never create the change that we need to improve not only the child's family but also the individual suffering those addictions. Experience that both John and I would have had is that there is limited access to actually meaningful interaction with services to support you. Especially when you think about keeping families together, the number of placements where families can access drug and alcohol rehab beds with support for continued interaction with their children, or even their children in those facilities, is almost non-existent.

Dr ZORBAS: I think without a concomitant increase in resourcing for services like alcohol and drug rehabilitation, the measures of this Bill will fail, whether they are drafted in their current form or with suggestions that we would make. There is a significant risk with the lack of resourcing we have in issues around the safety of children in care. As Rosie has said, this is a symptom of a bigger disorder.

J DAVIS: Thank you, Dr Zorbas and Dr Rock, for appearing today and for your submission. Your submission outlines various concerns about the Bill, not only in relation to Aboriginal child placement principle but also the family responsibility agreements, events of concern, the two-year cut-off of reunification, some of which you talked about there.

A broad question first of all. In your view which Bill—the current Bill we have or the proposed amendments—will keep and make children safer? Can you briefly explain why?

Dr ZORBAS: It is a difficult question to answer because it is a system in crisis. I think maintaining the status quo is not an option. Obviously, we have tendered a submission with our recommendations for the amendments and where we disagree with the intent of some of the Bill. If I had to choose, I would choose neither.

J DAVIS: You outlined and reiterated then that the issue is not—I do not want to put words in your mouth—necessarily the legislation, but everything that is around it; would that be correct?

Dr ROCK: It is an enormous piece of work. To keep children thriving, which is really the goal—safety is one of those key measures—we need to invest in child wellbeing, but family wellbeing as well. Looking at what these symptoms are—this dysfunction and antisocial behaviour that is leading to children being removed—we need to step back to those primary interventions that John has outlined and address those things if we want to see meaningful change within our families and in the broader community.

J DAVIS: You talked in your opening statement about the number of AOD beds that were available. We have heard that these amendments could further exacerbate young people's mental health. You may have said this, but can you tell the committee how many youth inpatient mental beds we currently have, where they are and what capacity they have to treat young people with acute mental health?

Dr ZORBAS: The youth inpatient program at Royal Darwin Hospital—you would have to check this with NT Health—I believe there are five inpatient beds currently in YIP and zero in Central Australia.

J DAVIS: Following up on that, what capacity does the system currently have to deal with a potential influx of young people with acute mental health concerns?

Dr ZORBAS: None.

Dr ROCK: We see children with acute behavioural disturbance presenting to the emergency department more frequently than previously. This is getting worse and it will only get worse with more childhood trauma experienced by children. I do not think we have a very good structure to deal with this.

It is often that these children will present to an emergency department. They will not be for a mental health admission because it is a behavioural disturbance, not a mental health illness. They may not fit a paediatric admission, so these children are then, almost by default, spat out to a child protection concern because the family are finding it difficult to deal with their child. We do not have access to rapid services to support them in a way that we would love to.

Often it is undiagnosed autism spectrum disorder, FASD, ADHD and other things that are going on for that child that might be manifesting or showing up now in this point in their life. Any increase in mental health presentations or behavioural disturbance for children and young people will cripple the system further.

Madam CHAIR: I have a quick follow-up on Dr Rosie's comment. You mentioned the diagnosis and stuff like that. If there is a better diagnosis earlier, would that assist with working out which services the child would need or the family support services then?

Dr ROCK: Absolutely. Early access to assessment, diagnosis and support services is critical. The earlier we are able to support families, the less likely they are to come to the attention of child protection services. That means we can then put in place supports that mean we can access parenting skills for parents and we can put in allied health supports so that child learn to communicate if that is part of their struggle. We can look at

ways the Education department can engage with that child better. We can end up completely changing the course. Early intervention and early diagnosis is critical.

Madam CHAIR: Thank you. Sorry, Justine.

J DAVIS: That is okay.

In relation to family responsibility agreements and events of concern—you touched on that in your submission—I am interested in your view on how you see that impacting on children and, in particular, the risks in relation to domestic violence and coercive control.

Dr ZORBAS: As a rule in healthcare, mandatory treatment orders and mandatory requirements for follow-up do not lead to good outcomes. They are broadly ineffective. You have to meet people where they are. Sometimes it is more appropriate for something to be seen through a lens of justice, at other times through a lens of public health and at other times both.

An analogy is the co-response system for acute mental health crisis in adults. Across Australia we have seen a rise in the use of these co-response units. Unfortunately, most are pilots rather than ongoing funded systems. The ides is that instead of uniformed police officers attending to a mental health crisis, a mental health nurse and a plain-clothes police officer—or more than one—will attend. You still have the power of the policing and legislative response, but presented differently and with a mental health skill set as part of the initial response as well. It leads to a drastic decrease in violent incidents, assaults against police and harm to patients from being apprehended in these situations and brought to the hospital.

There is a different way of delivering this care and a different lens of looking through these things. Obviously, we are here to represent doctors. We see everything through the lens of public health. Any investment in a measure like that can only lead to better outcomes down the track.

J DAVIS: To follow up, do you have any interest in coercive control in relation to domestic violence and how that might interplay with events of concern? I do not know if you have any comments on that. I think you may have referenced it briefly in your submission.

Dr ROCK: Anyone who has experienced trauma of any kind—whether it is domestic violence, coercive control or their own early childhood experiences—will have a response that is kicked off when they are engaging with authority figures or services that are perceived to be coercive. That can manifest in fight, flight, freeze or fawn-type behaviour. With those behaviours, you might see someone escalate. That is what John is speaking about with the plain-clothes police officer rather than someone in a uniform triggering a different response for people.

Through healthcare we often work with families. It is a focus on a therapeutic relationship. That is foundational to anything that we will make progress with. If, all of a sudden, that changes and we are now perceived as treating arms for authorities, that can be very harmful to the therapeutic relationship. It can rupture that relationship, unfortunately.

Mr HOWE: Thank you, both doctors, for coming today. You will get no argument from me. I have stated in parliament that I think government is always a blunt instrument when it comes to social change and medical outcomes. I agree with everything you are saying where investment gets outcomes, but this committee has to look at this Bill and decide if the changes it is making are good and we will support the legislation—that being the child's paramount safety. I agree with everything you have said, but when we are looking at this Bill for child protection, do you agree the child's safety is paramount? I note you said in your introduction that you would like to see culture and safety together. I challenge what you say. We all in this room are from a unique culture at all different levels. If there is ever conflict, what needs to be paramount?

Dr ROCK: I would say the child's wellbeing needs to be paramount. That wellbeing is more than just their safety.

Mr HOWE: On that, what do you consider under the term wellbeing?

Dr ROCK: Wellbeing relates to their development, growth, nutrition, psychological safety and opportunities to thrive. The connection to family, identity and culture is a part of that wellbeing, absolutely.

Mr HOWE: Again, you will have no disagreement, and that is all in the legislation. All that—the cultural, everything—is maintained. It is when a decision has to be made, and I know you have both come across this

in practice, and you are looking at risk and benefits. We have to make legislation on when a decision—and we have created a hierarchy, and we are stating safety as the first. I understand you just said wellbeing. Do you oppose that the paramount safety should be a priority?

Dr ZORBAS: I agree with everything you have said; there is a lot of agreement. I think where we diverge is what is encompassed by safety.

Specific to your question of conflict resolution, I completely agree that legislation is a blunt instrument. The intent of the legislation should be to create the strategic framework in which the operations are created by the Department of Child Protection, by NT Health and by various government agencies and non-government organisations in the field they work in. When we have conflict between the elements of safety that have to be judged on a case-by-case basis with those who are delivering the care for that child—that will involve potentially doctors, childcare workers, lawyers, police, the family and the people around that child, educators—it is not something that can be answered in legislation; it is far too complex and far too nuanced.

When we talk about cultural safety in this Bill our concern is the demotion of cultural safety below the level of physical safety. I do not think it is that simple. There are lots of elements to safety. We know that children who have roofs over their head, have access to education and who are not physically, emotionally, sexually abused by adults can thrive. By demoting one element of safety we take away that opportunity to better address that. I suppose that is the issue that we have with what has been worded in this legislation and these amendments. I am not a lawyer, I do not draft legislation, and I do not envy those who do, but I would imagine there is a way that we can have cultural safety sitting alongside the elements of physical safety and security.

Mrs ZIO: Thank you for attending. You have really cool names, both of you.

Like the Member for Drysdale, I agree with many things that you have stated today. There are many things that I am like, ‘Yep, yep, yep’. I guess where we disagree is in how we now try to resolve some of those things.

In your submission you have used the term ‘intervention’ to mean removal of a child, but in the context of child protection the term ‘intervention’ has a broader meaning. The Bill’s whole early intervention framework, like family responsibility agreements, proactive efforts and assistance, parenting programs, medical help, connecting families to services—in all of that removal is the last resort. It is not what the term ‘intervention’ means in this context. Can you talk to me about why you use the term ‘intervention’ in your submission, not relating to what we do to then support a child rather than just the term ‘removal’?

Dr ZORBAS: We represent doctors, and we coming here with a public health framework; words are used differently. There is an emphasis in these amendments on tertiary and secondary measures; family responsibility agreements being a secondary measure as to orders as well, tertiary elements—I suppose the orders are more of a tertiary intervention. What these amendments do not do is put primary preventive measures above the level of secondary and tertiary measures.

Looking at this from a public health lens in which I do not have to consider all the elements of operationalising the legislation, the argument is always in favour of primary interventions because they are more effective, cheaper and lead to better healthcare outcomes in the long term. When we look at the amendments in this legislation our submission tenders that there is not enough attention paid to those measures above and beyond the tertiary measures. There are a lot of amendments that pertain to tertiary measures only. You send the firefighters to where the fire is. We would want to see more resourcing, more framework and more structure around the primary measures rather than the tertiary measures.

Mrs ZIO: On that, can you point to a specific provision in the amended Act where protection that previously existed for Aboriginal children, or all children, has been removed or watered down rather than just relocated or extended to all children?

Dr ZORBAS: To point to one specifically, I would say that relegation of the ACPP in terms of cultural safety is one of the elements I know we have spoken a lot about today. That is one direct one.

We have also demoted the rights of families from a legal right to be part of the proceedings to an opportunity to participate in a lot of these family responsibility arrangements and operations.

Mrs ZIO: It has not been removed; it has just been moved.

Dr ZORBAS: It has not been removed …

Mrs ZIO: It has not been removed, just moved.

Dr ZORBAS: Correct. Things have been demoted; things have been watered down. It is not to say that the amendments that have been proposed are entirely unworkable, but when we look at it through a public health lens we see missed opportunities from a primary prevention point of view. From the model of healthcare that we exist in, where we see children day to day at the bottom of the cliff in the emergency department, the question that almost always comes to the doctors' minds is, 'If we had only done this particular thing back then'. I think Dr Rock referred to that a couple of times in her lived experience.

Mrs ZIO: I love that because I think that is what we are trying to do with this new legislation—early intervention as early as possible.

Madam CHAIR: Thank you, Dr Zorbas and Dr Rock. That concludes our time today.

The committee suspended.
