Northern Territory Mental Health Coalition

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 a representative from the Northern Territory Mental Health Coalition, Geoff Radford. Thank you for coming before the committee. We appreciate you taking time to speak to the committee and 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.

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

Mr RADFORD: I am Geoff Radford and I am the CEO of the NT Mental Health Coalition.

Madam CHAIR: Thank you, Mr Radford. Would you like to make any opening statements?

Mr RADFORD: Yes, please.

I start by acknowledging that we are meeting on the lands of the Larrakia people and pay my respects to elders past, present and emerging.

The Northern Territory Mental Health Coalition is the peak body for community-managed mental health services across the Territory. We represent a wide network of service providers funded by both the Commonwealth and the Northern Territory Government to deliver mental health services to Territorians, including directly to children and families engaged with the child protection system.

I am here today to speak to the submission the coalition lodged to this committee and to respectfully urge the committee not to recommend the Bill pass in its current form. Let me be direct about why, and I want to be equally direct that our position is grounded in evidence, not in opposition to the intent of the legislation. Every member of this coalition wants Territory children to be safe. We share that goal with the government and, I would suggest, every member of this committee.

I draw the committee's attention to statements in bold on page 3 of our submission. Research consistently shows that Aboriginal and Torres Strait Islander children have poorer mental health outcomes in out-of-home care and are less likely to receive adequate mental health support while in care, and parental mental health is a significant factor in child protection involvement. Untreated parental mental illness is one of the most consistent predictors of child maltreatment and child protection involvement.

Our submission identifies three substantive issues in the Bill as drafted. The first is the need to address the mental health needs of children entering out-of-home care. The evidence here is clear and specific to the NT. Linked administrative data shows that out-of-home care is associated with the highest risk of mental health hospitalisation among Territory adolescents, with Aboriginal and Torres Strait Islander young people disproportionately represented in that data.

The Bill does not currently, but is an opportunity to, introduce mandatory mental health screening upon entry to care, to fund therapeutic care plans and to introduce an enforceable commitment to trauma-informed service delivery. When we consulted our member organisations, we found that access to timely mental health assessment, mental health care and treatment is effectively non-existent across large areas of the Territory. One organisation serves a region of 162,000 square kilometres, with funding for one mental health nurse. Another reports waitlists measured in months. The Bill will operate in that environment without additional resourcing.

The second issue is the family responsibility agreement framework. Untreated parental mental illness is one of the most consistent predictors of child protection involvement in the evidence base. Addressing it through accessible funded therapeutic support is the most evidence-based route to reducing child protection responses. The Bill's expanded family responsibility agreement framework does the opposite; it strengthens punitive compliance obligations without providing a mechanism to ensure parents in psychological crisis receive therapeutic referral.

There is no requirement for independent legal or advocacy support before an agreement is entered into and no recognition that the diagnostic and therapeutic infrastructure that compliance would require simply does not exist. This is not a description of wilful noncompliance; it is a description of structural failure that the Bill will formalise.

The third issue concerns the Aboriginal and Torres Strait Islander Child Placement Principle. The NT already has the lowest rate in Australia of Aboriginal and Torres Strait Islander children in out-of-home care placed with Aboriginal and Torres Strait Islander kin. The principle is currently not being upheld, and the Bill proposes to formalise its circumvention. For children whose safety, wellbeing and mental health are inseparable from connection to family, kin, culture and country this is not a procedural change; it is a decision that will cause harm, and the research on this point is unequivocal and repeated in the weight of submissions made to this committee.

I note the Bill was introduced before the concurrent departmental review was concluded. This is not a standard of consultation consistent with the National Agreement on Closing the Gap or with the rights-based frameworks Australia is committed to. It is not in line with the expectation of the constituents you represent.

The coalition is not here to oppose the legislative amendments; we are here before this committee with expertise recommending amendments: prioritise the Aboriginal child placement principle; mandate funding and culturally safe mental health assessments within 21 days of entry to care; require mental health referral for parents within 14 days of intervention; and guarantee independent legal and advocacy support for family responsibility agreements. These amendments are achievable. They are evidence based and are the difference between legislation that claims to protect children and legislation that actually does.

The past couple of days I have been down the road at the alcohol and other drugs association of the Northern Territory's annual conference. A speaker I heard this morning said something important I want to share with you: structural inequalities matter. They lead to under-supported and over-represented populations in our systems.

Madam CHAIR: Thank you, Mr Radford.

Mr HOWE: Thank you, Mr Radford, for coming in. I understand and thank you for your statement. Constituents do expect this. My constituents expect it. I am speaking on behalf of the people of Drysdale, so I state for the record that point.

I do not think anyone disagrees that out-of-home care is not an ideal situation for a child's lifelong mental health; however, I have a very simple question: does the Mental Health Coalition believe there is a threshold when a child needs to be placed in care?

Mr RADFORD: That is not something that our members are often working within. We are supporting children and families who are in touch with that system. That decision lies with the statutory body.

Mr HOWE: Yes, which is the legislation we are trying to pass. My question still remains to the Mental Health Coalition: does the organisation believe there is a time that a child needs to be placed in care?

Mr RADFORD: There are times when there is significant intervention required, and we are asking that the legislation also ensure that the mental health needs and developmental needs of children and families in touch with that system are supported in the Act.

Mr HOWE: I note that the United Nations Convention on the Rights of the Child is in your submission. You have said, correct me if I am wrong, that the Bill goes against the United Nations rights of the child; however, it speaks explicitly on the primary need for safety. It lists, as the current Bill does, a number of other things. I want you to expand on why the coalition believes it is going against it, when, in my view, it is not.

Mr RADFORD: The human rights of Territorians, particularly children and families in touch with the child protection system, are incredibly important. Legislation—and not just this legislation—at times has a risk of removing those rights, so it is important that in the development and amendment to this Bill that the human rights of people in touch with that system are upheld. The Bill does not currently make that explicit, and it could.

Mr HOWE: What would you like to see in the Bill that would clarify that?

Mr RADFORD: If the Bill was viewed through a human rights lens, then it would include the rights and liberties of individuals under the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the Declaration on the Rights of Indigenous Peoples.

J DAVIS: Thank you for appearing today, Mr Radford.

You have outlined and touched on the issues with supports for Territorians with mental health needs. In your submission you said that there are more than 8,000 Territorians with moderate to severe mental illness who currently receive no psychosocial support across all the services available to them; a member organisation covering 162,000 kilometres with a single mental health nurse; and the Bill proposes a hard two-year limit on reunification. You say that complex trauma presentations routinely require longer than that.

In your view and the view of the Mental Health Coalition, what happens when issues cannot be addressed within two years, not because of unwillingness but because the services do not exist?

Mr RADFORD: When families are in touch with the child protection system, the likelihood of them increasing their involvement in that system only increases without adequate intervention. The earlier we can intervene and provide support to children and families outside of that system, the greater likelihood of outcomes, the shorter the mental health recovery time, the less the amount of investment required.

J DAVIS: Specifically, in relation to that recommended amendment that there is a two-year cap, how do you see that playing out, given that you have also outlined workforce shortages et cetera here in the Territory?

Mr RADFORD: Two years is a very short period for working with families that have significant complexity. Lots of the programs that we work within mean that there are long-term relationships that need to be formed with families who already have significant mistrust in the system due to past and current practices. There is a fear when services go to visit families that their children will be removed just for being involved with some of the NGO sector, let alone the child protection system. If you were to consider that it would maybe take six months in order to develop a meaningful relationship in order to commence therapeutic work, that already cuts into a quarter of that two-year period. Having a limitation on that places additional undue pressure on families dealing with myriad complexities.

J DAVIS: In relation to that, I am not sure if you are able to comment on what that would mean for a child if under this Bill there is a hard cut-off of two years—there is no proposal for consideration of the context—and what that might mean for a child and family if they are prevented from reunification after two years, not through unwillingness but through a lack of access to the supports that they may need.

Mr RADFORD: The risk is that it creates further harm not just for the child but their extended family as well without the opportunity to restore the family unit. The Aboriginal and Torres Strait Islander perspectives of social and emotional wellbeing indicate clearly how important the connections to family, culture and country are, and that time limit risks severing that.

Mr HOWE: In the view of the Mental Health Coalition, can you explain to the committee what the long-term psychological effects are, particularly if we go to the most extreme forms of domestic and family violence—regardless of background, heritage, whatever—especially with things like child abuse and sexual abuse? Can you inform the committee of the impacts that has, particularly if conducted by a primary carer, be it a parent or a carer from the family unit?

Mr RADFORD: Of course it causes significant harm to the child and to the family unit. The impact is long-lasting and requires significant therapeutic and relational support to the child in order to address that significant harm, and that takes a lifetime.

J DAVIS: Continuing from that, in your view or in the view of the coalition, do these amendments do anything to address the concerns that were just raised by the Member for Drysdale?

Mr RADFORD: The legislation, I think, is an opportunity to strengthen the intervention and wraparound support, particularly into developmental disability and mental health in order to reduce that impact. I think we could mandate some specific times, as I outlined—funded and culturally safe mental health assessments within 21 days of entry to care, and mental health referral for parents within 14 days of intervention.

J DAVIS: I understand that is what you propose could happen, but in terms of the amendments we are looking at and the concerns raised by the Member for Drysdale, do the current amendments do anything to

address those concerns in relation to the lack of safety for children in relation to domestic violence, sexual assault et cetera?

Mr RADFORD: I think it leaves ambiguity that should be clearer.

Mr YOUNG: Thank you, Mr Radford, for attending today. I have a question regarding the Aboriginal child placement principle. In your submission you raised concerns about the changes made by the Bill to the principle and suggest amendments to the Bill to strengthen mental health supports. Would you like to explain your concerns on what impact you believe this change will have, particularly for children?

Mr RADFORD: Yes, sure. As outlined in my submission, so far the Territory—as you have heard from other evidence as well—has such a low rate of Aboriginal and Torres Strait Islander children in out-of-home care placed with Aboriginal and Torres Strait Islander kin. The principle is currently not being upheld. The opportunity is here now to name it and strengthen it in the legislation to ensure that principle is embedded in not just the legislation but the practices within the department. That would then extend to the delivery of services.

Mr YOUNG: I think you have explained this, but can you expand more on how mental health supports could strengthen within the Bill and through government policies, but also what resourcing would be required to implement those supports, and maybe the resourcing to implement the Aboriginal child placement principle too?

Mr RADFORD: The mental health system in the Northern Territory is geared towards acute, when people are very unwell. It is also geared significantly towards the urban centres, particularly Darwin but also Alice Springs. If you are living outside Darwin and Alice Springs, your access to the support is quite limited and unequal. It means that people are more likely to be transported away from their home, where they might have natural supports and protective factors around them in order to maintain and improve their mental health. I thought that was important context for your question, in my opinion.

Mr YOUNG: The other part was the resourcing for the implementation of the ACPP.

Mr RADFORD: Yes, supporting families in this context requires significant skills, training and relational work that our sector is still building. We have limited investment in our sector, which means it is difficult for us to build a sector that can adequately respond to this level of complexity. Member organisations consistently report strong intersections, not just in mental health but in alcohol and other drugs, disability, domestic and family violence and food insecurity, which means that many of our mental health providers and social and emotional wellbeing organisations delivering social and emotional wellbeing programs are supporting families to deal with some really difficult circumstances. It makes it challenging to address mental health concerns without those immediate needs met.

Mr YOUNG: I have one more question. I am trying to think how to word it. It is about the placement of children. What evidence do you see with the wellbeing and mental health of young people when they are placed in out-of-home care compared with kinship care and the importance of ensuring that children stay with their family where they can?

Mr RADFORD: Young people across Australia, including in the Northern Territory and at the Youth Round Table, consistently report mental health and wellbeing in their top two priorities. It is of significant concern to them because between the ages of 12 and 24 it is seen to be a forming stage for them. Without adequate wraparound supports, they lack hopefulness for the future and opportunities, and it is difficult for them to see themselves being able to live the good lives that they want to live—without those structural inequalities, and the safety nets, as I outlined before, that allow them to thrive.

Mrs ZIO: Thank you for coming today. We appreciate your submission and the time you have taken out of your day to meet with us. I have a bit to say before I ask my question.

In your submission the coalition argues that this Bill will fail because mental health services are inadequate, but gaps in those services exist whether this Bill passes or not. I have not seen, and nobody has brought to the table, any evidence that the pre-amendment framework has produced better outcomes for children despite these gaps. We know the NT's child protection crisis predates these amendments. Your submission highlights the significant mental health burden experienced by children involved in the protection system, and it acknowledges that many children entering care have already experienced substantial trauma.

We have met before, and I have met with many different organisations. Many people know that I very much support what you have said about youths having mental health as one of their top two priorities. I know that is the case, and I agree with you 100% that many cases—or all cases—that come through the child protection system should undergo mental health assessments in care plans to get the support they need. I am sure that you will agree that the data would confirm that not all but much of the trauma is at the hands of families relating to a child's living situation, their exposure to violence, alcohol, drugs and all those things that happen in these environments.

We are trying to implement an Act that puts safety and early intervention at the core of its work. My question to you is: how do we ensure that a child's right to safety, stability and healthy development is not continually delayed while we wait for an adult's circumstances to improve, particularly where those issues may take years to resolve?

Mr RADFORD: Thank you for the question and your statement preceding it as well. Families and parents are often left out or have limited supports when they are involved in the child protection system. The system often focuses entirely on the child or children, which means that the wellbeing of the family, particularly the trauma attached with child removal, is not adequately addressed and the wraparound supports that might be required to address that trauma are often unfunded and do not have the level of multisystemic therapy that is needed in order to give that family the best opportunity to thrive and to restore the opportunity for reunification. Apologies, I am stumbling on my words.

Mrs ZIO: That is okay. Thank you for that. Throughout your submission there is significant discussion about systems, processes, consultation and rights. If we place those to the side for just one moment and focus solely on the child, do you agree that when there is a genuine conflict, prioritising cultural placement preferences and ensuring a child is immediately safe from harm, the child's safety must always be the paramount consideration? Do you agree with that?

Mr RADFORD: I would not place them to the side. I would say the human rights of families and children involved in the child protection system should be at the forefront of the lens in which we are viewing this legislation.

Mrs ZIO: Is that different to the safety of a child?

Mr RADFORD: The human rights should be the lens in which we are viewing the safety of the child.

J DAVIS: As a follow-up from that, because this is an issue we are talking about a lot, it sounds like what you are saying is that the current law in terms of how it defines—I cannot remember what the term is—the wellbeing or whatever, is broader than safety, which is what is in the Act, and that when you talk about a human rights lens that includes the safety that the Member for Fannie Bay was talking about. I want to check, very clearly, does your answer mean that you think a child should be left in an unsafe situation because of culture?

Mr RADFORD: No, that is not what I am saying. I am saying that the way we view families and children in complex situations that require intervention, that intervention and the treatment under the Act should be through a human rights lens.

Madam CHAIR: Thank you, Mr Radford, for coming before the committee today.

Mr RADFORD: I appreciate the opportunity to speak.

The committee suspended.