Submission to the Inquiry into Racism, Hate and Violence Directed at Aboriginal and Torres Strait Islander People

Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs – Parliament of Australia

April 2026

Consumers of Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia's First Nations' communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses the Indigenous Australian Lived Experience Centre's (IALEC) universal definition of lived experience for First Nation communities:

> *A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.*

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences in how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

CoMHWA recognises that this language is not uniform, and we have sought to identify all individual contributors to this submission by their preferred language. This includes identifying people as Indigenous or First Nations based on their preference.

2.4 About the consultation

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The Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs adopted an inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander People on 4 March 2026, following a referral from the Minister for Indigenous Australians, Senator the Hon Malarndirri McCarthy.

The Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs will inquire into racism, hate and violence directed at Aboriginal and Torres Strait Islander people, including:

1. *The nature, prevalence and impact of racism, hate and violence towards First Nations people, including trends over time.*
2. *The effect of online platforms on the reach, prominence and harm caused by racism and hate directed at First Nations people.*
3. *Initiatives that are effective in combating racism targeted at First Nations people and reduce individual and collective harm.*
4. *The threat posed by ideologically motivated extremism towards First Nations people and the role of intelligence and law enforcement agencies in protecting the community from that threat.*

5. *The effectiveness of avenues for reporting and responding to racism against Aboriginal and Torres Strait Islander people, including the consistency, timeliness and appropriateness of outcomes across jurisdictions and institutions.*
6. *Other matters related to racism, hatred and violence directed at First Nations people.*

CoMHWA have chosen to address 1, 3 and 5 of the Terms of Reference, as these terms align best with the insights our members can provide.

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs, Inquiry into Racism, Hate and Violence Directed at Aboriginal and Torres Strait Islander People.

We base our submission on:

- Responses to a survey distributed to members of CoMHWA who identify as Aboriginal, Torres Strait Islander or both and have a personal lived experience of mental health challenges or distress.
- Ongoing data collection and input from CoMHWA's Individual Advocacy and Peer Pathways (service navigation) programs.
- Ongoing feedback from our Aboriginal Lived Experience Advisory Group.
- Ongoing consultation with consumers in Western Australia on joint priorities for an improved mental health system.
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).

Aboriginal and Torres Strait Islander people are disproportionately subject to involuntary treatment, detention in psychiatric hospitals, and other human rights violations.[1] CoMHWA advocates for reforming mental health laws to uphold all consumers' human rights to make decisions and have control over their own lives. CoMHWA advocates for a holistic response to the experiences of Aboriginal consumers' distress caused by racism, hate and violence, including their experiences of systemic racism and colonisation. To this end, CoMHWA advocates for:

- The implementation of a Human Rights Act that incorporates the protections under the United Nations Declaration on the Rights of Indigenous Peoples.
- Aboriginal mental health consumers' access to mental health services that are codesigned and accountable to Aboriginal Lived Experience Expertise.

[1] Australian Institute of Health and Welfare. (2025). Involuntary treatment. Retrieved 31 March 2026 from https://www.aihw.gov.au/mental-health/topic-areas/involuntary-treatment#Who-receives

- Community supports and supported decision-making mechanisms that assist Aboriginal consumers to deal with the harms of colonisation and racism need to be:
  - culturally safe and free from systemic racism; and
  - give effect to the United Nations Declaration on the Rights of Indigenous Peoples and the Gayaa Dhuwi (Strong Spirit) Declaration.

4. Discussion

4.1 The nature, prevalence and impact of racism, hate and violence towards First Nations people, including trends over time.

"Racism within our mental health system will not be fixed by a checklist or some training. It will take a structural change that acknowledges our connection to kinship and country. This cannot be done for people. Each person needs to find these connections for themselves. When the government reduces this to a tick box, it further entrenches systemic racism and leads staff within the system to draw racist conclusions."[2]

Aboriginal and Torres Strait Islander experiences of racism, violence and hate are linked to the ongoing nature of colonial Australia and the systemic racism embedded within its structures. The nature of systematised racism in the form of colonisation is a cause of major harm to the mental health of Aboriginal people within Western Australia. Some Aboriginal consumers have experienced overt interpersonal racism within the mental health system. These experiences should be addressed individually but also seen as the product of systemic racism because it emerges out of the broader normalisation of understandings of race and practices that entrench inequality on the basis of race, and it also reproduces systemic racism because it entrenches oppression and preserves systems that operate on the basis of assumptions of racial difference.[3]

CoMHWA's Individual Advocates assist Aboriginal consumers and their family, carers & kin to navigate the mental health system. They have reported that during interactions of Aboriginal consumers and their

[2] Feedback to CoMHWA from an Indigenous Lived Experience Advocate (Noongar woman).

[3] CoMHWA. (Undated). *Literature review – Systemic Racism and Aboriginal and Torres Strait Islander People's Social and Emotional Wellbeing.* https://comhwa.org.au/wp-content/uploads/2025/09/Thematic-Literature-Review-Systemic-Racism-and-Aboriginal-and-Torres-Strait-Islander-Peoples-SEWB.pdf

family, carers & kin with the mental health system, racism is at work in assumptions that are made about Aboriginal and Torres Strait Islander consumers and their families, including:

- that Aboriginal consumers are incapable or unwilling to comply with treatment plans.
- the family/kin not being capable of or willing to care for the person appropriately.
- drug use and drug-seeking behaviours.
- Aboriginal consumers and their family, carers & kin lack the knowledge and ability to understand their own circumstances, challenges, treatment, and the mental health system.

Racism, hate and violence are significant mental health stressors that are faced by Aboriginal and Torres Strait Islander people in Western Australia.[4] These stressors come from not only individual acts of abuse and aggression, but also the systemic responses to these incidents. Furthermore, systemic racism causes the institutions charged with supporting Aboriginal and Torres Strait Islanders through mental health challenges caused by colonisation to be less effective.

One of the ways that the nature of systemic racism is demonstrated is in institutional attitudes towards traditional healing practices. Traditional and cultural healing should be accessible to consumers, and statutory requirements should ensure it is.[5] However, consumers are often either denied access to traditional healing, or traditional healing is seen as something to be trialled once and then discarded as unhelpful. Efforts to engage in traditional healing are often experienced by consumers as "box-ticking" rather than a genuine attempt to provide culturally appropriate, holistic approaches to care. Hospitals seem to place a large burden on cultural healing to have immediate, significant outcomes and result in a person never needing mental health support again. This is evident in hospitals saying they don't want to engage a cultural healer again if it is something they tried once and they feel it didn't work to immediately address and essentially remove a person's mental health challenges. Even when there has been a history of an Aboriginal consumer improving after being helped by traditional healing to the point that they are discharged from the hospital. The same consumer may be denied the cultural healing on subsequent admissions, on the logic that it did not result in immediate and permanent recovery.[6] Such a standard is, notably, not a burden that they place onto judging the effectiveness and legitimacy of clinical systems and Western mental health approaches.

[4] Australian Indigenous Health Infonet. (2024). Social and Emotional Wellbeing. https://healthinfonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/

[5] *Mental Health Act 2014* (WA) s 50, 81, 189.

[6] Feedback from Individual Advocates supporting Aboriginal consumers, their family members, carers and kin.

4.1.1 The Impact

When Aboriginal and Torres Strait Islander people seek support, they frequently experience racism, and their experiences of racism go beyond individual-level interactions with staff. That is to say, common approaches to understanding racism in service settings tend to see racism as a matter of purely interpersonal interactions, "individual attitudes evidenced in problematic ideas, expressions or behaviours,"[7] but this, among other things, leaves unexamined the frameworks and processes that underpin and inform prejudicial attitudes and problematic ideas and behaviours, and the degree to which racism comes to inform the culture, structure and operations of mental health services and facilities.[8]

Experiences of racism cause intense distress, which is compounded by the exhausting feeling of needing to consistently navigate 'around' racism in accessing needed supports.[9] Aboriginal Mental Health Consumers described the experiences of racism within the mental health system as harming them through misdiagnosis, higher levels of restrictive practices and the suspension of their human rights. Testimony of Aboriginal women to CoMHWA's Aboriginal Lived Experience Advisory Group (ALEAG), included the impact on themselves and their family, carers and kin, of racism within the mental health system:

"Professional people are making personal decisions from a professional position of power. They are using their personal bias opinion to treat Aboriginal people. We get the same treatment because of stigma rather than being seen as individuals."

"Doctors look at Aboriginal men and assume they are dangerous just based off how they look."

While recent data suggests that Aboriginal and Torres Strait Islander people access mental health and clinical services at similar rates to non-Indigenous people, they experience worse outcomes, which implies

[7] Watego, C., Singh, D., & Macoun, A. (2021). *Partnership for Justice in Health Scoping Paper on Race, Racism and the Australian Health System.* Lowitja Institute. https://doi.org/10.48455/SDRT-SB97, p. 15.

[8] Isaacs, A. N., Pyett, P., Oakley-Browne, M. A., Gruis, H., & Waples-Crowe, P. (2010). Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: Seeking a way forward. *International Journal of Mental Health Nursing*, 19(2), 75–82. https://doi.org/10.1111/j.1447-0349.2009.00647.x

Australian Institute of Health and Welfare. (2023). Racism and Indigenous wellbeing, mental health and suicide. https://doi.org/10.25816/K4R5-E446 , p. 13.

Heard, T. R., McGill, K., Skehan, J., & Rose, B. (2022). The ripple effect, silence and powerlessness: hidden barriers to discussing suicide in Australian Aboriginal communities. BMC Psychology, 10(1), 23. https://doi.org/10.1186/s40359022-00724-9

[9] Ziersch, A. M., Gallaher, G., Baum, F., & Bentley, M. (2011). Responding to racism: Insights on how racism can damage health from an urban study of Australian Aboriginal people. Social Science & Medicine, 73(7), 1045–1053. https://doi.org/10.1016/j.socscimed.2011.06.058

Kairuz, C. A., Casanelia, L. M., Bennett-Brook, K., Coombes, J., & Yadav, U. N. (2021). Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review. BMC Public Health, 21(1), 1302. https://doi.org/10.1186/s12889-021-11363-x

services are not providing appropriate support.[10] Aboriginal consumers who have experienced systemic racism may have a reasonable expectation that further contact with services will expose them to these issues again. This deters help-seeking and leads people to avoid services often until an Emergency Department visit is needed.[11] Emergency departments are not well designed to assist people in mental health crises, and Aboriginal and Torres Strait Islander people are often discriminated against in Emergency Departments. The resulting harm includes Aboriginal consumers receiving inappropriate treatment and assessment, prompting many to self-discharge without any further service options to turn to.[12]

In Emergency Departments, the assumption that Aboriginal consumers are drug-using or seeking can have far-reaching implications. When a consumer is labelled with the diagnosis of drug-induced psychosis, they can be treated as if their symptoms are not real or related to mental health, and that the consumer is to blame for their own symptoms and distress. One lived experience advocate stated,

"I've seen drug induced psychosis be stuck on someone after a five minute consult, ignoring the much more obvious (in each case) diagnosis of OCD, PTSD and an intellectual disability. It is also a diagnosis which can make it much harder to get services, government payments, and support."

Almost all members of CoMHWA's ALEAG have had frequent interaction with the oppressive sides of the mental health system. They also reported never receiving counselling for their issues and having little confidence in mainstream counsellors having any knowledge about them, their identities and experiences as Aboriginal people, and the issues present for them, including the social and emotional wellbeing issues they would like to address.

Aboriginal mental health consumers report that systemic racism plays a role in escalated state interventions, including the use of police and criminalisation during periods of mental health crisis, the removal of children from the care of their families, and the suspension of Aboriginal consumers' right to consent (or refuse to consent) to medical interventions.

[10] Australian Institute of Health and Welfare & National Indigenous Australians Agency. (2023a). *Measure 3.10 Access to mental health services*. AIHW, Australian Government. https://www.indigenoushpf.gov.au/measures/3-10-access-to-mental-health-services

Dudgeon, P., Boe, M., & Walker, R. (2020). Addressing Inequities in Indigenous Mental Health and Wellbeing through Transformative and Decolonising Research and Practice. *Research in Health Science*, *5*(3), 48–74. https://doi.org/10.22158/rhs.v5n3p48

[11] Australian Institute of Health and Welfare, 2023, p. 12.

Heard et al., 2022.

[12] Askew, D. A., Foley, W., Kirk, C., & Williamson, D. (2021). "I'm outta here!": a qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital. BMC Health Services Research, 21(1), 907. https://doi.org/10.1186/s12913-021-06880-9

Members of CoMHWA's ALEAG described their experiences with state interventions:

"When someone isn't okay, we don't get support. When we reach out for help, it is ignored until there is a crisis. Then we get intervention where our rights and children are removed."

"Police come and make things worse. They trigger psychosis, and then they tell you that you can't make decisions for yourself because of your psychosis."

The Impact of "Colonial Load" and Racially Driven Deficit Discourse

Both Aboriginal consumers and workers described the additional burden they carry due to the mental health system's failure to understand their cultural obligations. This failure of the system to recognise this burden it creates is an example of how systemic racism and personal biases lead to the routine framing of Aboriginal and Torres Strait Islander people's social and emotional wellbeing and health in terms of a 'deficit discourse' or lack and failure. These systemic blind spots in the structures that produce disadvantage[13] and "the failure by health providers to supply adequate, culturally appropriate services"[14] shift the blame and place responsibility for addressing disadvantage on Aboriginal and Torres Strait Islander people as individuals.[15] As one Aboriginal Mental Health Worker commented:

"The term "cultural load" should be reframed, the load isn't created by our culture. This should be reframed as "colonial load"."[16]

Failures to understand cultural context, when combined with mental health stigma, can place Aboriginal consumers at risk of significant harm. Furthermore, biomedical approaches often frame mental health challenges as biological deviations from the 'norm.'[17] These approaches bleed into other interactions that Aboriginal consumers have with systems. Experiences such as wanting to travel to fulfil cultural obligations can be framed by workers as an Aboriginal consumer "failing to understand" or "not having insight into their illness", which can be used as a justification for involuntary treatment. Cultural obligations to store

[13] Bond, C. J., & Singh, D. (2020). More than a refresh required for closing the gap of Indigenous health inequality. *Medical Journal of Australia*, *212*(5), 198. https://doi.org/10.5694/mja2.50498

[14] Fogarty, W., Bulloch, H., McDonnell, S. & Davis, M. (2018). *Deficit Discourse and Indigenous Health: How narrative framings of Aboriginal and Torres Strait Islander people are reproduced in policy*, Lowitja Institute. https://www.lowitja.org.au/wp-content/uploads/2023/05/deficit-discourse.pdf

[15] Watego et al., 2021, p. 15.

[16] Theme of feedback from a joint meeting between the CoMHWA's Statewide Aboriginal Mental Health Network (A network of non-clinical Aboriginal Mental Health Professionals) and the CoMHWA's Aboriginal Lived Experience Advisory Group

[17] Rhodes, L. (2019). The Colonising Effect of Western Mental Health Discourses. *Social Work & Policy Studies: Social Justice, Practice and Theory*, *2*(2). https://openjournals.library.sydney.edu.au/index.php/SWPS/article/view/14182, p. 7.

important possessions for family members and kin can be treated by housing workers as "hoarding" and seen as a marker of the Aboriginal consumer "being too unwell to maintain a tenancy". Obligations to care for extended family members and kin are labelled as evidence of incapacity to manage finances and used as evidence that the state should manage the finances of the Aboriginal consumer. Failure to grasp the cultural context a consumer is experiencing has the impact of extra labour, as the Aboriginal consumer must explain how community and roles work. This impact is often delivered when a consumer is most vulnerable, such as when they are in involuntary treatment, threatened with eviction or experiencing other significant stressors such as Family Domestic Violence. The vulnerability and external stressors may significantly reduce someone's ability to explain the cultural context. When the individual consumer cannot carry that colonial load, the cultural default and racist conclusions determine the course of their lives, which may result in the suspension of their human rights, including the right to withdraw consent to medical treatment.[18]

4.1.2 Examples of these impacts on Aboriginal consumers in practice

These examples demonstrate how the observations of Aboriginal consumers and the academic writings on the role of systemic racism play out in practice in the mental health system.

Example 1: The case of K – Summary of [2025] WASAT 15

K is an Aboriginal man who was born deaf and mute. As a 6-year-old, he was observed by a travelling teacher to be "a very capable and enthusiastic learner, held back only by his linguistic needs."[19] "Fast forward to the age of 25, and K had no recognisable way of communicating and a minimal amount of communication with his mother and a few family members, which involved their own style of sign language."[20] K was frequently distressed by an inability to be able to access money, frustrations with communications and exploitation, including being assaulted. However, during K's interactions with the mental health system, K was given various diagnoses related to mental health and intellectual disability. Of specific concern to this inquiry should be the diagnosis of Schizophrenia/schizophreniform disorder, intellectual disability, Foetal Alcohol Spectrum Disorder and Cognitive impairment.[21] WA State Administrative Tribunal Member Haigh found no evidence to support these diagnoses.[22]

[18] Examples given as feedback from Individual Advocates supporting Aboriginal consumers, their family members, carers and kin.

[19] K [2025] WASAT 15 para 1-2

[20] K [2025] WASAT 15 para 4

[21] K [2025] WASAT 15 para 188-201, 205-208.

[22] Ibid.

Member Haigh noted the evidence of the nurse that anti-psychotic medication administered to K via depot shot may be perceived as positive, as the person "may be more subdued and placid". This echoes the experiences of Aboriginal consumers, family members, and kin to CoMHWA who attribute the disproportionate number of anti-psychotics prescribed to Aboriginal men to a method of restrictive practice rather than medical need.

CoMHWA feels it is important that the inquiry consider if systemic racism and individual biases may have been at play in the diagnosis of K with Foetal Alcohol Spectrum Disorder, particularly that Aboriginal families are not capable of caring for their children, or misuse alcohol and other drugs. Member Haigh, further, noted that the diagnosis of K with Foetal Alcohol Spectrum Disorder in 2024 was made by a doctor who gave evidence that "she **assumes** there would have been supporting documents confirming this diagnosis in K's past medical history, but that she currently could not find it"[23] (emphasis in the original). Member Haigh found no evidence that this diagnosis was made prior to 2024, despite being given extensive evidence of K's interactions with the medical system through a longitudinal investigation undertaken by the Office for the Public Advocate.[24]

Example 2 – the experience of D[25]

D is an Aboriginal teenage boy (still a minor) who lives with his mother, with whom he has a close and loving relationship. D has an ongoing mental health care team due to his diagnosis of a psychosis disorder, which his mother helps him manage, including waking him up to take medication and monitoring his well-being. One day, his mother notices D speaking to himself and giggling. She is worried that this may be an early indicator that his mental health is declining. She proactively reaches out to her son's hospital care team. The mother does not report that she is worried that he will hurt himself, someone else, or that he appears to be distressed. The mother states that the young man has agreed to come into the hospital the next day. However, instead of peacefully allowing D and his mother to voluntarily attend the hospital as planned, the hospital chose to escalate the situation, causing significant harm. Early the next morning, police and hospital workers came to the house demanding entry. The family are scared by the police but does not report any threat or fear from the young man, who was sleeping. The mother tells the group that she will facilitate the young man coming to the door after she has woken him and he has had a chance to get dressed. The young man wakes up and goes to shower. The police and others become agitated by waiting and prepare to force entry. This includes preparing door-breaching equipment, such as battering

[23] Ibid, para 179.

[24] Ibid para 201.

[25] Report to CoMHWA's individual advocacy team shared with consent (some details have been changed to protect the dignity and privacy of those involved)

rams. Police enter the home, handcuff the young man, and then drag him from the home. This begins a cycle of distress for the young man, where, during his hospital admission, he is restrained by hospital staff. D remained in a cycle of acute admissions that included force and restraint. During one of these subsequent admissions, D experienced significant violence. D's mother witnessed three security guards pin her son down and drag him into another room. During the incident, the mother attempted to assertively advocate for her son. Hospital staff then labelled D's mother as aggressive and as posing a risk of violence towards staff, despite the mother never actually being violent. This significantly limited D's ability to see his mother during his hospitalisation.

Aboriginal women who care for members of their family/kin frequently report to us that their attempts to advocate are assumed to be violent or aggressive. CoMHWA's ALEAG members reported:

> *It is a common tactic of service providers who are racist to turn the blame on the victim.*

4.2 Initiatives that are effective in combating racism targeted at First Nations people and reducing individual and collective harm.

4.2.1 The framework for effective initiatives already exists

Currently, the effectiveness of strategies to combat racism, including systemic racism within the mental health system, is undermined by successive governments' lack of prioritisation and follow-through on strategies, agreements and commitments to address racism.

CoMHWA's Community Engagement Officer, in Aboriginal Mental Health (Yamatji man), reported:

"It is frustrating to see report after report done on the Aboriginal people being launched with much fanfare, then watching the novelty of the occasion drain quickly away from each one, and witness those reports being placed on a shelf to gather dust. This has gone on for too long. The reports and their recommendations and advice must be implemented in culturally appropriate ways, otherwise it won't work. There has to be a collaboration of Western ways and Aboriginal ways under the mantle of governance."

"Aboriginal professionals possess intimate knowledge about this way of working, but lack the power to decide to make a difference. Self-determination must come to the fore and be given sound support by the authorities for there to be any advances in addressing mental health amongst WA Aboriginal Nations and communities."

“Aboriginal service providers and communities have the answers to almost all the issues that impact upon Aboriginal people and which in turn cause mental health problems amongst their people and communities.”

A lack of accountability mechanisms has led governments to fail to prioritise or implement reforms to ensure that services are culturally safe and fit for purpose.[26] The current nature of funding and policy cycles limits the capacity of the mental health system to address systemic failures, including systemic racism.[27] The systemic racism of the mental health system is structured into every part of the system, from commissioning to frontline delivery. During commissioning, it is rare that allocation of services and funds considers the specific, culturally appropriate services that are on Country.[28] Structural misconceptions and biases about the capability of Aboriginal people led to the organisations that are the most capable of providing culturally safe, appropriate services, Aboriginal-controlled organisations, not receiving the funding they need to provide services to Aboriginal consumers and their communities. [29]

When effective initiatives that reduce the exposure of Aboriginal consumers to systemic racism within the mental health system are implemented, they have excellent results. However, access to these spaces often feels fragile and Aboriginal consumers fear that the programs may be defunded or the consumer may be exited if they are “too unwell”. This is illustrated by the experiences of D, the consumer, from example 2, which we discussed earlier (here).

An Aboriginal-led community team is now working with D and has a good relationship with his mother. The community team engages with D through culturally appropriate activities. D has been connected to a mentor from his own community who acts as a role model for what it means to be a man, which is important to his self-worth and his family. This culturally appropriate service is making a significant difference to D’s community connection, which had been disrupted when D and his mother moved to their current housing. The team have built rapport with D and takes a supported decision-making approach.

[26] Australian Productivity Commission, 2024.

Jumbunna. (2025). *Closing the Gap Independent Aboriginal and Torres Strait Islander–led Review Community Report 2025*. https://www.coalitionofpeaks.org.au/independent-review-of-closing-the-gap, p. 9.

[27] Hunter, E. (2020). Indigenous mental health: the limits of medicalised solutions. *Australasian Psychiatry*, *28*(1), 55–57. https://doi.org/10.1177/1039856219875050

[28] Dudgeon, P., Darwin, L., Hirvonen, T., Boe, M., Johnson, R., Cox, R., Gregory, L., McKenna, R., McKenna, V., Smith, D., Turner, J., Von Helle, S., & Garrett, L. (2018). *We are not the problem, we are part of the solution: Indigenous Lived Experience Project Report*. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute. https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/lived-experience-report-final-nov-2018.pdf, p. 26.

[29] NACCHO. (2021). *Inquiry into Mental Health and Suicide Prevention: Submission to the House Select Committee on Mental Health and Suicide Prevention*. https://www.naccho.org.au/app/uploads/2022/04/NACCHO-Submission-to-Inquiry-into-Mental-Health-and-Suicide-Prevention.pdf

However, D’s mother is fearful that if D becomes unwell again or the team suspect he is not taking his medication, they will pass him back over to the hospital, where he re-enters a cycle of distress and physical force.

4.2.2 Dismantling Systemic Racism in Mental Health Needs Quality Data and Research to Ensure Initiatives are Effective in Reducing Individual and Collective Harm

Effective initiatives to address systemic racism in the medical system are often based on quality data gathered using data sovereignty principles. If the government wants to undertake successful initiatives that combat systemic racism in the mental health system and reduce the harm it causes, it must follow through on commitments to gather data and report on strategies to address racism. Currently, these commitments often go unfulfilled.[30] The tools needed to identify and measure institutional and systemic racism have been created but are currently underutilised.[31]

When data and research are not held by First Nations researchers, they often fail to contribute to improvements in social and emotional well-being[32] and do not align with decolonising approaches led by First Nations researchers.[33] There is a wide body of health reporting on Aboriginal mental health from a deficit perspective, which represents Aboriginal consumers as a “problem”, while neglecting to include their perspectives. This often appears in dominant research approaches that frame Aboriginal and Torres Strait Islander people as objects of study rather than active partners and leaders capable of setting the focus of research and having ownership over the data.[34] The dominant research perspective is likely to have

[30] Australian Productivity Commission, 2024.

[31] Marrie & Marrie, 2014; Marrie, A. (2017). *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Public Hospital and Health Services*. https://www.qhrc.qld.gov.au/resources/reports/health-equity

[32] Kennedy, M., Bennett, J., Maidment, S., Chamberlain, C., Booth, K., McGuffog, R., Hobden, B., Whop, L. J., & Bryant, J. (2022). Interrogating the intentions for Aboriginal and Torres Strait Islander health: a narrative review of research outputs since the introduction of Closing the Gap. *Medical Journal of Australia*, *217*(1), 50–57. https://doi.org/10.5694/mja2.51601

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[33] Harfield, S., Pearson, O., Morey, K., Kite, E., Canuto, K., Glover, K., Gomersall, J. S., Carter, D., Davy, C., Aromataris, E., & Braunack-Mayer, A. (2020). Assessing the quality of health research from an Indigenous perspective: the Aboriginal and Torres Strait Islander quality appraisal tool. *BMC Medical Research Methodology*, *20*(1), 79. https://doi.org/10.1186/s12874-020-00959-3

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[34] Mayes, C. (2020). White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare. *Journal of Australian Studies*, *44*(3), 287–302. https://doi.org/10.1080/14443058.2020.1796754

Milroy, H., Kashyap, S., Collova, J., Mitchell, M., Derry, K. L., Alexi, J., Chang, E. P., & Dudgeon, P. (2022). Co-designing research with Aboriginal and Torres Strait Islander consumers of mental health services, mental health workers, elders and cultural healers. *Australian Journal of Rural Health*, *30*(6), 772–781. https://doi.org/10.1111/ajr.12945

contributed to the dearth of research and data about Aboriginal and Torres Strait Islander people's social and emotional wellbeing and mental health, and the impact of systemic racism.[35] For example, it was not until 2021 that a research project "recorded for the first time the words of Aboriginal women within the inpatient unit, including their perceptions of factors which may promote or impede a culturally safe environment."[36] Considering that Aboriginal and Torres Strait Islander people are more likely to be exposed to the oppressive functions of the mental health system, such as involuntary treatment, seclusion and restraint, the fact that the perspectives of these women themselves only came to be considered as valuable to research 5 years ago illustrates the limitations of this colonial research paradigm. The result of this research was able to "offer insights to mental health nurses who seek to provide person-centred care in a therapeutic and culturally secure environment."[37]

Palawa scholar Professor Maggie Walter describes the collective harm caused by failures to address systemic racism in data collection about Aboriginal people as "BADDR data".[38] BADDR is an acronym for blaming, aggregates, decontextualises, deficit and restricted:

"What BADDR means is that many researchers and governments have collected and told the stories of our data in a way that ***blames*** *us if our health is bad. These researchers and governments can often mix information about the health experiences of all mobs into one group of 'Aboriginal people' (****aggregates****). The stories they tell about our health might not explore the full context of our lives (****decontextualised****). Instead, these stories might focus on what is going wrong for us instead of what is working well (****deficit****). Finally, mob only have limited ways to access our own health research data (****restricted****)."*[39]

Australian Productivity Commission, 2024.

[35] Kilian, A., & Williamson, A. (2018). What is known about pathways to mental health care for Australian Aboriginal young people?: a narrative review. *International Journal for Equity in Health*, *17*(1), 12. https://doi.org/10.1186/s12939-018-0727-y, p. 3.

[36] Bradley, P., Lowell, A., Daiyi, C., Macklin, K., Nagel, T., & Dunn, S. (2021). It's a little bit like prison, but not that much: Aboriginal women's experiences of an acute mental health inpatient unit. *International Journal of Mental Health Nursing*, *30*(4), 917-930. https://doi.org/10.1111/inm.12843 p.1.

[37] Bradley, P., Lowell, A., Daiyi, C., Macklin, K., Nagel, T., & Dunn, S. (2021). It's a little bit like prison, but not that much: Aboriginal women's experiences of an acute mental health inpatient unit. *International Journal of Mental Health Nursing*, *30*(4), 917-930. https://doi.org/10.1111/inm.12843

[38] Walter, M. (2018). The voice of indigenous data: Beyond the markers of disadvantage. Griffith Review (60), 256-263. Available at https://search.informit.org/doi/10.3316/ielapa.586241932732209

[39] Uink, B., Liddelow-Hunt, S., Wear, K., Dau, D., Andrews, L. (2025). Yarning about Aboriginal Health Research Data in Boorloo (Perth): Community Report. Wungening Aboriginal Corporation. Available for download: https://www.wungening.com.au/wp-content/uploads/2025/11/YAAHRDIB-Community-Report.pdf p. 14

In Western Australia, effective initiatives in research and data collection concerning Aboriginal and Torres Strait Islander people have been carried out in line with Maiam nayri Wingara Indigenous Data Sovereignty principles.

Maiam nayri Wingara defines Indigenous Data Sovereignty as "the right of Indigenous peoples to exercise ownership over their data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, distribution, and reuse of Indigenous data."[40] The Maiam nayri Wingara Indigenous Data Sovereignty principles must then be interpreted and applied by local communities in order that they are applied in a culturally appropriate fashion. For research undertaken in Boorloo (Perth), Aboriginal Elders have guided how those the principles "look and sound for mob in Boorloo".[41]

In applying local interpretations of the Maiam nayri Wingara Indigenous Data Sovereignty principles, effective initiatives in research have been undertaken. They include:

- Walkern Katatdjin (Rainbow Knowledge) study by The Kids Research Institute, ECU, Kulbardi Aboriginal Centre at Murdoch University, and the University of Western Australia. The project was the result of Aboriginal and Torres Strait Islander LGBTQA+ community advocacy and was led by Aboriginal investigators, including Aboriginal LGBTQA+ investigators and staff.[42]
- Birdiya Maya Homelessness Research Project undertaken by Wungening and National Drug Research Institute, Curtin University. The research team was led by the community and engaged Aboriginal researchers, including a Noongar Chief Investigator, to ensure cultural safety. This project moved beyond the tokenism often seen in research to engage a wide range of Aboriginal Elders, chosen by Elders Groups from across Perth. The Aboriginal Elders sat on a Community Ownership Group who, in combination with Wungening, ensured that strict data protocols were adhered to.[43]
- Western Australian Aboriginal Child Health Survey Linked Data Study undertaken by The Kids Research Institute. The study attempts to collect information on a range of indicators of the "health, wellbeing and life outcomes of Aboriginal children and young people in WA".[44] The project combines community co-design with Aboriginal leadership and governance structures to ensure the project is fit for purpose.

[40] Maiam nayri Wingara & Australian Indigenous Governance Institute (2018). Indigenous Data Sovereignty Communique Indigenous Data Sovereignty Summit. Canberra, ACT. Available at https://static1.squarespace.com/static/5b3043afb40b9d20411f3512/t/5b6c0f9a0e2e725e9cabf4a6/1533808545167/Communique%2B-%2BIndi genous%2BData%2BSovereignty%2BSummit.pdf

[41] Ibid, p. 16.

[42] Ibid, p. 18.

[43] Ibid, p 19.

[44] Ibid.

4.2.3 Immediate Priorities to Reduce Individual and Collective Harm

The starting point for successful interventions to reduce both systemic racism in the mental health system and the collective harm is de-centring interventions based on the medical model and trusting First Nations people to design and deliver effective services. The government could immediately improve the experiences of Aboriginal people who encounter the mental health system by:

- Prioritisation of funding Aboriginal-controlled place-based services co-designed by and for local First Nations people to ensure that Aboriginal people receive services free from systemic racism and that interventions respect cultural protocols and the kinship system.
- Implementing the *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan*.[45] The Gayaa Dhuwi Declaration Framework and Implementation Plan is the practical implementation steps designed by Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), the national Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB), mental health, and suicide prevention leadership body, to secure a fit-for-purpose mental health system for Aboriginal and Torres Strait Islander peoples.
- Institute data sovereignty principles so that communities are able to best evaluate and respond to their own needs. Fund research and data collection that uses decolonising approaches led by First Nations researchers.
- Recognising the expertise, value and history of Aboriginal lived experience peer work and practices. “Peer work is the flow between different knowledge systems, different worlds, and different environments. It navigates the space in between First Nations and Western knowledge systems and the many worlds that First Nations Peoples must find their way through every day. Peer work flows with an exceptional strength and capacity to understand, negotiate, and balance the differences of often competing systems.”[46]

[45] Gayaa Dhuwi (Proud Spirit) Australia (2025). *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan.* https://www.gayaadhuwi.org.au/wp-content/uploads/2025/02/GDPSA-Implementation-Plan_WEB.pdf

[46] Tony Lee, Raeylene Mckenna, George Morseau, Andrew Bacon, Kiarnee Baguley, Shannon Cowdrey-Fong, Amy Bertakis, Travis Shorey, Tracey Smith, Aboriginal and Torres Strait Islander Lived Experience Centre Team (Vicki Mckenna, Eliza Kitchener, Nathan Meteoro)

4.3 The Effectiveness of Avenues for Reporting and Responding to Racism against Aboriginal and Torres Strait Islander People, Including the Consistency, Timeliness and Appropriateness of Outcomes Across Jurisdictions and Institutions.

Themes from feedback meetings with Individual Advocates supporting Aboriginal consumers, their family members, carers and kin, included:

"Responses to complaints can be performative. Hospital staff may make a display of attending meetings in shirts featuring Aboriginal art and acknowledging Country. However, often there are little to no practical results from these meetings, and when consumers or their family, carers or kin follow up, they are treated as the problem."[47]

"The responses to complaints about racism can be bizarre and dismissive. We once wrote a letter to a minister outlining an Aboriginal consumer's experience of racist treatment. The response was along the lines that they had reviewed the consumer's case file and had found no evidence of racism. It makes you wonder if the Minister's office believed that the consumer's treatment could only have been racist if staff had written in the file, 'I treated this person badly because of their race'."

Aboriginal and Torres Strait Islander people who are impacted by the mental health system often have very little say in their treatment. Further, when Aboriginal consumers' right to consent is removed through mental health or guardianship laws, there are no mechanisms to ensure that decisions concerning their treatment are culturally appropriate. Complaint mechanisms are not culturally safe or appropriate. It is CoMHWA's opinion that this sits in contradiction to Australia's international obligations under both the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples.

The number of formal complaints made does not represent the extent of experiences of racial discrimination that Aboriginal and Torres Strait Islander people experience. The power imbalances and fear of future forced proximity to staff who have caused harm mean that many Aboriginal consumers fear re-victimisation or further interactions with the racist systems that cause them distress.[48] It is important to

[47] Feedback from Individual Advocates supporting Aboriginal consumers, their family members, carers and kin.

[48] Truong, M., Allen, D., Chan, J., & Paradies, Y. (2021). Racism complaints in the Australian health system: an overview of existing approaches and some recommendations. Australian Health Review, 46(1), 1–4. https://doi.org/10.1071/AH21189

understand that due to the catchment system used by public acute mental health services, such as public hospitals, it is likely that a consumer who has complained about racism during involuntary treatment or detention may be readmitted involuntarily and receive treatment from the same staff that they complained about. Staff in involuntary mental health settings have the power to compel treatment and use physical force against Aboriginal consumers. This combination, along with the perception that meaningful resolution is unlikely, is a major barrier to Aboriginal consumers' ability to seek recourse. Further, it can appear that when complaints by Aboriginal consumers about terrible experiences they have, mentioning racism can create a barrier to solving the problem. If consumers state that they believe the experience was racially based, the response of the service or institution can often be to get defensive about racism rather than look at the whole picture of how a consumer was treated and address the harm it caused.

Further, complaint systems are bureaucratic, difficult to navigate, and ill-equipped to deal with systemic complaints. Hospitals, mental health services and government departments often have well-resourced legal teams to respond to complaints. By contrast, Aboriginal consumers have little access to advocacy and/or legal support to enable them to navigate these systems and make complaints, due to these services being poorly funded and resourced.[49]

When Aboriginal consumers seek remedies through legislative mechanisms, they often face significant barriers due to the complexity of anti-discrimination laws, complaints frameworks, and the associated documentation. For example, an Aboriginal consumer can lodge a complaint with their state or territory’s anti-discrimination commission or with the Australian Human Rights Commission, but if their complaint is not resolved there, the court is the only option for follow-up. Court processes concerning experiences of discrimination are often highly technical, expensive and often exempt from legal aid funding.[50]

Complaint mechanisms cannot be used to ensure or monitor mental health services and systems are free from racism, as this places those who have the least power in the system as responsible for its functioning. Mental health systems and services should have positive duties to ensure that systems are culturally safe and free from racism, including systemic racism.

[49] Allison, F. (2013). A limited right to equality: Evaluating the effectiveness of racial discrimination law for indigenous Australians through an access to justice lens. Australian Indigenous Law Review, 17(2), 3–25. https://www.jcu.edu.au/__data/assets/pdf_file/0011/119999/jcu_144196.pdf, p. 15.

[50] Truong, M., Allen, D., Chan, J., & Paradies, Y. (2021). Racism complaints in the Australian health system: an overview of existing approaches and some recommendations. Australian Health Review, 46(1), 1–4. https://doi.org/10.1071/AH21189

5. Conclusion

Racism and Aboriginal consumers' experiences of racism within the mental health system cannot be addressed without a concerted effort to address systemic racism. The government has the roadmaps, strategies and reports that outline how these issues can be resolved. The *National Anti-Racism Framework* and *the National Agreement on Closing the Gap* are significant systemic initiatives aimed at addressing the inequities in health, justice, and social outcomes caused by colonisation. Unfortunately, failure to act has meant that Australia has not made real progress in implementing the United Nations Declaration on the Rights of Indigenous Peoples in law, policy, or practice, including physical and mental health.[51] [52] Reviews by the Productivity Commission and Aboriginal and Torres Strait Islander researchers of the *National Agreement on Closing the Gap* have found that governments have not prioritised reform. Low prioritisation has limited the implementation of policies to ensure that services funded by governments are culturally safe and free from systemic racism.[53] The current enquiry presents an opportunity for governments to shift away from short-term thinking about policy and funding and take action that would result in real change.

Aboriginal and Torres Strait Islander people have already invested significant resources in formulating the practical steps that can be taken. The *Gayaa Dhuwi Declaration Framework and Implementation Plan*[54] is a set of practical steps designed to secure a fit-for-purpose mental health system for Aboriginal and Torres Strait Islander peoples, which, if undertaken, will be a significant positive initiative to ending the harm caused by systemic racism in the mental health system.

Below, we have summarised the recommendations spread throughout this submission. In implementing these recommendations, we can address the individual and collective harm caused by systemic racism to Aboriginal and Torres Strait Islander consumers, family, carers, kin and communities who have interactions with the mental health systems.

[51] Australian Human Rights Commission. (2022). *National Anti-Racism Framework Scoping Report 2022.* https://humanrights.gov.au/sites/default/files/document/publication/national_anti-racism_framework_scoping_report_2022_0.pdf, p. 21.

[52] ANTAR (2021). *Racism in Healthcare.* https://antar.org.au/wp-content/uploads/2021/05/Racism-in-Healthcare-Backgrounder.pdf

[53] Australian Productivity Commission, 2024.

Jumbunna. (2025). *Closing the Gap Independent Aboriginal and Torres Strait Islander–led Review Community Report 2025*. https://www.coalitionofpeaks.org.au/independent-review-of-closing-the-gap, p. 9.

[54] Gayaa Dhuwi (Proud Spirit) Australia (2025). *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan.* https://www.gayaadhuwi.org.au/wp-content/uploads/2025/02/GDPSA-Implementation-Plan_WEB.pdf

6. Recommendations

To reduce and work to eliminate the prevalence, harm and impact of racism against Aboriginal people who come into contact with the mental health system, CoMWHA makes the following recommendations:

- *Prioritise funding Aboriginal-controlled place-based services co-designed by and for local First Nations people to ensure that Aboriginal people receive services free from systemic racism and that interventions respect cultural protocols and the kinship system.*

- *Implement the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan. The Gayaa Dhuwi Declaration Framework and Implementation Plan is the practical implementation steps designed by Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), the national Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB), mental health, and suicide prevention leadership body, to secure a fit-for-purpose mental health system for Aboriginal and Torres Strait Islander peoples.*

- *Institute data sovereignty principles so that communities are able to best evaluate and respond to their own needs. Fund research and data collection that uses decolonising approaches led by First Nations researchers.*

- *Recognise the expertise, value and history of Aboriginal lived experience peer work and practices. "Peer work is the flow between different knowledge systems, different worlds, and different environments. It navigates the space in between First Nations and Western knowledge systems and the many worlds that First Nations Peoples must find their way through every day. Peer work flows with an exceptional strength and capacity to understand, negotiate, and balance the differences of often competing systems."*[55]

- *Immediately improve systemic responses to the experiences of Aboriginal people who need to make complaints concerning racism in their interactions with the mental health system by:*

    - *Embedding culturally appropriate, Aboriginal and Torres Strait Islander, lived experience governance in the reporting and response mechanisms.*

    - *Funding a range of Individual Advocacy spaces for Aboriginal consumers to ensure they have choice and control over who supports them through complaint processes.*

    - *Introducing positive duties for mental health systems to address systemic racism within mental health systems and services.*

[55] Lee, T., Mckenna, R., Morseau, G., Bacon, A., Baguley, K., Cowdrey-Fong, S., Bertakis, A., Shorey, T., Mckenna, V., Kitchener, E., & Meteoro, N. (2024). *Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide: A learning tool for all peer workers and organisations*. Aboriginal and Torres Strait Islander Lived Experience Centre, Black Dog Institute. https://www.blackdoginstitute.org.au/wp-content/uploads/2024/08/mhc24-63121-v7-ilec-blackdog-aboriginal-lived-experience-peer-led-workforce-guide-v11-july-2024-final-version-attachment-1.pdf

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