UTS

Australian Human Rights Commission

Health Inequities in Australia:

A Scoping Review on the Impact of Racism on Indigenous and Other Negatively Racialised Communities' Health Outcomes and Healthcare Access

September 2025

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This scoping review was commissioned by the Australian Human Rights Commission to explore the health impacts of racism in Australia, particularly as they affect Aboriginal and Torres Strait Islander Peoples and other negatively racialised communities. The findings aim to provide evidence-based recommendations that support the Commission's broader goals under the National Anti-Racism Framework.

Recommended Citation

This document can be cited as:

Demant, D., Manton, D., Manton, J., & Saliba, B., & Avery, S. (2024). *Health inequities in Australia: A scoping review on the impact of racism on Indigenous and other negatively racialised communities' health outcomes and healthcare access.* School of Public Health, Faculty of Health, University of Technology Sydney. Commissioned by the Australian Human Rights Commission.

Acknowledgement of Country

UTS acknowledges the Gadigal People of the Eora Nation, the Boorooberongal people of the Dharug Nation, the Bidiagal people and the Gamaygal people upon whose ancestral lands our university stands. We would also like to pay respect to the Elders both past and present, acknowledging them as the traditional custodians of knowledge for these lands.

As part of this research, we also acknowledge the traditional custodians of the lands where the individual studies were conducted. We recognise the significant contributions of these custodians to knowledge, culture and community.

Further information

This publication can be found in electronic format on the Australian Human Rights Commission's website: humanrights.gov.au/our-work/publications

Illustrations by Bree Buttenshaw for Saltwater People (2024)

Design and layout: Claudia Williams, Australian Human Rights Commission

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ISBN: 978-1-921449-11-6

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Foreword

Many members of this research team have firsthand experience with racism, either personally or within our communities. While research and metrics provide critical insights, they cannot fully capture the deeper, lived realities of the pervasive and systemic nature of racism in health systems and healthcare.

Racism in healthcare is rarely a single event, but a structural reality embedded in practices and institutional cultures that unfolds over time, shaping access, interactions, and health outcomes.

There is no medical diagnosis or health system metric to capture that uneasy feeling of being torn between speaking out and staying silent, fearing the consequences for oneself and others.

If racism makes us sick, then challenging racism makes us sicker. The burden of addressing racism should not fall on those who experience it. Instead, institutions must take this responsibility of dismantling discriminatory structures as a fundamental aspect of their clinical governance and ethical practice.

As we present this review, we recognise both the value of empirical research and the need for ongoing work that fully integrates the voices and experiences of those affected. We hope this work serves as a resource for policymakers, healthcare professionals and researchers committed to ensuring that Australia's health system is equitable, just, and inclusive for all.

– The Authors

Executive Summary

Racism is a pervasive determinant of health that undermines the health and wellbeing of individuals and communities. It contributes to the onset and progression of social, emotional, psychological and physical ill-health, and the persistent nature of racism within society prevents individuals from achieving recovery and optimal health outcomes.

This scoping review examines the impacts of racism on health outcomes and healthcare access for Aboriginal and Torres Strait Islander Peoples and other negatively racialised communities in Australia. Commissioned by the Australian Human Rights Commission, it aims to provide a comprehensive analysis of racism as a critical determinant of health disparities based on an analysis of academic literature. Racism operates at interpersonal, systemic and structural levels, compounding historical injustices and socio-economic disadvantages. By mapping evidence from diverse disciplines, the review contributes to the National Anti-Racism Framework and offers actionable insights to reduce health inequities.

The findings demonstrate that racism is embedded in Australia's social and institutional systems and shows that racism is not an isolated or individualised issue; it is a structural phenomenon with profound implications for public health. For Indigenous Australians, systemic racism, rooted in colonial policies and culture, manifests in cultural disconnection, intergenerational trauma and inequitable access to healthcare. Other negatively racialised communities experience acculturative stress, workplace discrimination and educational barriers, further exacerbated by societal and structural biases. These experiences in both groups are compounded by discrimination in healthcare settings including neglect, stereotyping and substandard care, which results in delayed care, poorer health outcomes and a sustained mistrust of healthcare systems. The cumulative effects of racism manifest in consistent poor mental health, increased chronic disease risk and reduced life expectancy, highlighting the urgent need for change. The literature highlights the importance of addressing racism not only as a public health issue but as a systemic crisis that requires immediate attention.

The review identifies key research gaps, including the need for longitudinal studies, intersectional analyses and culturally safe interventions. Recommendations include strengthening legislative frameworks, embedding cultural safety standards in healthcare and expanding interpreter services to ensure equitable access. Additionally, the review underscores the importance of community-led initiatives and the co-design of research tools to address diverse experiences of racism effectively. These strategies aim to contribute to a systemic change aimed at dismantling discriminatory practices and foster inclusive health policies that promote equity for all Australians.

Recommendations

Our recommendations are based on the findings of this scoping review. By positioning these recommendations at the forefront of this report, we aim to provide clear, evidence-based actions that can guide policymakers, healthcare practitioners, researchers and educators in addressing the systemic inequities documented in the subsequent sections.

These recommendations are not presented in isolation but are the result of extensive analysis of peer-reviewed literature. The chapters that follow provide the necessary context, evidence, and rationale underpinning each recommendation, illustrating the pervasive nature of racism in healthcare and its long-term consequences on health outcomes.

The recommendations are categorised into two key areas: *Recommendations for Policy and Practice* and *Recommendations for Future Research*. The first set of recommendations offers concrete strategies to reform institutional policies, strengthen cultural safety in healthcare, and embed anti-racism initiatives across systems. The second set outlines critical research priorities needed to fill existing knowledge gaps and ensure that future interventions are informed by robust, context-specific evidence.

The Closing the Gap Priority Reform 3 (Transforming Government Organisations) highlights the importance of eliminating institutional racism in policies and service delivery, shifting power to communities by embedding Indigenous leadership in decision-making and ensuring accountability through transparent monitoring and reporting mechanisms (National Indigenous Australians Agency, 2020). These principles are reflected throughout our recommendations, which prioritise structural change over individualised interventions. The recommendations are designed to transform the way government organisations interact with Aboriginal and Torres Strait Islander communities, ensuring that services are culturally safe, equitable and responsive to the needs of those most affected by systemic racism.

While the recommendations in this chapter serve as a starting point for action, they must be read in context with the detailed findings presented later in this report which provide an in-depth examination of the structural, systemic and interpersonal dimensions of racism in Australian healthcare.

Recommendations for Policy and Practice

1. Strengthen Cultural Capabilities in Health Services

a. Participation in culturally appropriate training to ensure respectful treatment should be standard for all healthcare practitioners. Literature demonstrates that culturally safe/capable care can bridge distrust, address bias and improve service engagement. A recent Cochrane systematic review demonstrates some positive impact of these trainings with no adverse outcomes reported in any study conducted on these trainings (Horvat et al., 2014).

b. Provide anti-racism training for health professionals through micro-credentials[1] or open online courses that are accessible to all professionals, regardless of their employer, to ensure equitable access to best-practice training. Literature supports that anti-racism training can alter provider behaviours, fostering equitable treatment across racial groups (Hassen et al., 2021). Existing training offerings should be supported by the relevant government bodies to ensure these are kept up-to-date and enable them to run and to avoid costly duplications.

c. Continue encouraging health programs led by Aboriginal and Torres Strait Islander and other negatively racialised communities, allowing for culturally relevant service design. Evidence supports that community-led initiatives better address the unique health needs of these populations (Campbell et al., 2017).

2. Implement Cultural Safety Standards in Healthcare

a. Develop and enforce national standards that mandate culturally safe environments within healthcare, promoting respect and understanding of Indigenous health perspectives (Curtis et al., 2019). This recommendation is based on Indigenous cultural safety theory; evidence demonstrates that culturally safe care environments enhance Indigenous Australians' trust in healthcare systems (Jones et al., 2020). The Australian Health Practitioner Regulation Agency (AHPRA), medical and nursing schools, and health service providers are responsible for implementing anti-racism training, as they regulate professional standards and oversee training for healthcare workers. This training should be integrated into medical and nursing curricula within the relevant accreditation cycles, with mandatory training for existing healthcare professionals phased in over five years to align with professional development cycles and providing sufficient time for the development of relevant structures. This training may be combined with other trainings for a smoother integration at lower cost for compliance and integration.

1 Micro-credentials are short, focused and competency-based qualifications that certify an individual's skills or knowledge in a particular area such as anti-racist practices. They are commonly designed to be flexible, aligning with specific industry needs. Micro-credentials are typically more concise than traditional degrees and may be delivered through online platforms, workshops, or intensive courses.

Recommendations

3. Support the Development of Anti-Racist Frameworks in Health and Social Services

a. Establish guidelines and toolkits to assist health and social services to ensure non-discriminatory treatment, addressing racial biases in service delivery. This recommendation directly aligns with the priorities outlined in the National Anti-Racism Framework (Australian Human Rights Commission, 2024), particularly the call for targeted, systemic reforms in health and social services that embed cultural safety, anti-racism education and community-led approaches. These guidelines should be developed in collaboration with affected communities and experts in equity-focused service provision. They should provide practical strategies, including staff training on implicit bias, culturally responsive care frameworks and mechanisms for addressing complaints related to discrimination. By embedding the Framework's principles such as institutional accountability, community leadership, and culturally safe practice into everyday service delivery, these resources can operationalise national anti-racism goals within the health and social service sectors. Implementing clear, actionable policies can help build trust, improve service accessibility and promote equitable health outcomes for all populations (Hassen et al., 2021). The federal and state health and social services departments, professional regulatory bodies and peak health and social service organisations have joint responsibility for developing and implementing anti-racist frameworks, as they oversee service delivery standards and professional practice guidelines. Initial national guidelines and toolkits should be developed within three to five years, providing health and social service providers with practical, evidence-based strategies to ensure non-discriminatory treatment. This timeline accounts for the necessary stakeholder engagement, policy drafting and piloting of initial frameworks required.

4. Expand Interpreter Services in Healthcare

a. Integrate interpreter services as a standard within healthcare services, ensuring equal access to quality care. Research indicates that language barriers in healthcare contribute to delayed treatment and adverse health outcomes, exacerbated by lack of culturally appropriate communication (Ali & Watson, 2018; Rasi, 2020). The federal Department of Health and Aged Care, state health departments, hospitals and community health services are responsible for expanding interpreter and translation services, as they manage healthcare funding and service accessibility. Interpreter services should be expanded within three to five years, with sustainable funding secured. This timeframe allows for workforce expansion, recruitment and additional training of interpreters, ensuring they are available in key healthcare settings, particularly in emergency departments and primary care clinics.

5. Address Historical Trauma in Health Policies

a. Acknowledge and integrate the impact of historical trauma into health policies for Aboriginal and Torres Strait Islander populations, fostering culturally safe and responsive healing (Menzies, 2019; Watego et al., 2022). Theoretical frameworks on intergenerational trauma highlight the ongoing effects of historical injustices on health outcomes (Joo-Castro & Emerson, 2021). Immediate commitments, such as formally recognising historical trauma in national health, education, and social service strategies, should be made within two to three years, as these changes can be incorporated into existing frameworks with minimal structural delay. Comprehensive integration of trauma-informed approaches across healthcare services, educational curricula, and community support programs should occur over a longer period of time to allow for collaboration with Indigenous communities, curriculum reform and

workforce training. A phased approach ensures that policies are both immediately responsive and systematically embedded, fostering culturally safe, trauma-informed environments across multiple sectors

b. Federal and state governments should provide sustainable funding for the integration of traditional healing practices into healthcare services through partnership with Aboriginal and Torres Strait Islander communities (Asamoah et al., 2023; Australian Human Rights Commission, 2024).

6. Embed Anti-Racist Educational Policies

a. Embed anti-racist education policies to combat racism in primary, secondary and tertiary education environments, supporting Indigenous and other negatively racialised students' development and wellbeing. Studies show that educators are generally in favour of enacting strategies aimed at reducing racism but may lack knowledge and skills to do so (Forrest et al., 2016). Studies show that education systems significantly impact mental health and long-term outcomes, as racial discrimination can hinder academic engagement (Alansari et al., 2020; Bodkin-Andrews & Carlson, 2016). The federal and state education departments, the Australian Curriculum, Assessment and Reporting Authority (ACARA), and teacher training institutions are responsible for embedding anti-racist education policies, as they oversee curriculum development, teacher accreditation, and professional development. In the tertiary education sector, universities and higher education regulators, such as TEQSA, should ensure anti-racism principles are embedded across teaching and learning policies, course content and student support services. This includes integrating anti-racism training into educator development programs and ensuring inclusive curriculum review processes that address racial bias in course materials. These policies should be developed within two years and fully implemented across schools and universities within five years. Two years aligns with standard curriculum review processes in most states and allows time for consultation with educators, researchers and community representatives to ensure the policies are evidence-based and practical. Five years ensures that teacher training programs integrate anti-racism education, allowing for a gradual rollout that provides adequate training for existing educators.

7. Review and Strengthen Anti-Discrimination Laws

a. Implement the recommendations of the Australian Human Rights Commission's Free and Equal report (Australian Human Rights Commission, 2023b) by introducing a federal Human Rights Act and considering relevant amendments to existing anti-discrimination laws, including the Fair Work Act, the Racial Discrimination Act, and state-based Anti-Discrimination Acts. These reforms should include explicit provisions that empower people to report racism in the workplace and other settings. This recommendation is grounded in legal theory as research shows that comprehensive legislation can prevent discrimination and provide legal recourse for marginalised communities. The Free and Equal report also supports expanding the Australian Human Rights Commission's powers to monitor and enforce compliance with a positive duty to eliminate racial discrimination. Gaze et al. (2017) in their review of the Fair Work Act also came to the conclusion that "equality remains elusive in Australia", arguing that the Fair Work Act's current provisions are insufficient for achieving substantive equality. The federal and state governments are responsible for strengthening anti-discrimination laws, as they have the authority to introduce, amend and enforce legal protections that address systemic racism. Legislative

amendments should be introduced within two years, with enforcement mechanisms in place within three years to allow for necessary legislative processes and compliance structures. This timeframe provides sufficient time for consultation with relevant stakeholder communities and bodies.

8. Support Economic Opportunities for Marginalised Communities

a. Implement workplace policies that secure job opportunities and protections for individuals, promoting economic stability and reducing job strain (Spector, 2015). Workplace stress and discrimination impact mental health, supported by models like "job strain" showing that lower job security affects health outcomes (Daly et al., 2018). The federal and state governments are responsible for providing a framework for the implementation of workplace policies that promote job security and protections for marginalised communities, as they regulate employment laws, workplace rights and economic policies. Immediate actions, such as strengthening workplace anti-discrimination policies and enforcing existing employment protections, could be implemented within one year, as these changes primarily require legislative amendments and enforcement mechanisms that build on existing structures. Longer-term structural reforms, including the development of targeted employment programs and initiatives to reduce job strain, should be rolled out over a longer period, allowing for consultation with industries, employer compliance measures, and workforce transition planning.

9. Ensure Representation in Policy-Making

a. Facilitate representation and true co-design in public health and social policy discussions, giving voice to community needs. Studies show that participatory governance, ensures that policies align with community realities. Underrepresentation in decision-making processes perpetuates inequitable policies and service delivery (Yearby et al., 2022). The federal and state health departments, hospital boards and policy advisory bodies are responsible for ensuring diverse representation in governance, as they have control over health policy and related funding decisions. Appropriate representation of marginalised groups, including Aboriginal and Torres Strait Islander Peoples and other negatively racialised communities, should be mandated on relevant governance bodies. The changes are structural and deep and require significant consultation and assessment.

Recommendations for Future Research

The following recommendations are designed to address critical gaps in understanding and responding to racism's impact on health and wellbeing in Australia. These research priorities are not only essential for deepening our knowledge of the mechanisms and effects of racism but also for driving evidence-based solutions that support equitable policy and practice. By exploring the intersection of systemic and interpersonal racism with health outcomes, such studies have the potential to inform interventions, improve service delivery, and foster inclusive environments across sectors. Generating new and relevant knowledge is instrumental in addressing persistent disparities and shaping effective long-term strategies to support Aboriginal and Torres Strait Islander Peoples and other negatively racialised communities.

These research priorities complement the recommendations for policy and practice by providing a clear evidence base that is needed to design and implement effective interventions. As an example, longitudinal studies on the health impacts of racism will provide critical data to strengthen anti-discrimination laws and embed cultural safety standards in healthcare, ensuring policies are grounded in the lived experiences of those affected. Similarly, examining the role of cultural safety and exploring intersectional impacts of racism will inform the development of culturally responsive training and support frameworks in health and education, fostering environments that are inclusive and equitable. Research into workplace discrimination and its mental health effects will guide policies that promote safe and supportive work environments, while studies on culturally tailored mental health interventions and public health campaigns can shape initiatives that address stigma and enhance service engagement.

1. Develop (and Support) Longitudinal Studies on Racism and Health

a. Conducting further longitudinal research to understand the long-term health impacts of systemic and interpersonal racism on Aboriginal and Torres Strait Islander and other negatively racialised populations is essential and required. Funding is required for this particularly resource-intensive type of research. This approach addresses the need to capture the cumulative effects of racism, as seen in studies with longitudinal designs.

2. Examine the Role of Cultural Safety in Health Outcomes

a. Research how culturally safe environments influence health outcomes, particularly within Aboriginal and Torres Strait Islander and other negatively racialised communities. Literature suggests that cultural safety promotes engagement and reduces disparities, essential for evidence-based policy development.

3. Explore Intersectional Impacts of Racism

a. Study how overlapping identities (e.g., race, gender, disability) affect experiences of racism and associated health outcomes. Intersectional theory indicates that multiple marginalisations intensify health risks, as shown in diverse identity-focused studies

4. Assess Mental Health Impacts of Workplace Discrimination

a. Focus future research on how racial discrimination in workplaces affects psychological health among marginalised communities. There is currently limited research in Australia examining the specific mental health impacts of racial discrimination in workplace settings. In the Australian context, the existing literature largely focuses on general health or employment disparities, with

few studies exploring the direct and cumulative mental health consequences of workplace discrimination, particularly for Aboriginal and Torres Strait Islander Peoples and other negatively racialised communities. Addressing this gap is essential to inform workplace policies, anti-discrimination frameworks, and culturally safe employment practices that promote mental health equity and foster inclusive work environments.

5. Investigate Racism in Social Service Engagement

a. Explore barriers to accessing social services among Aboriginal and Torres Strait Islander and other negatively racialised people, examining how racism deters engagement with and completion of care. Findings on service discrimination suggest that marginalised individuals avoid essential services, leading to poorer health outcomes

6. Identify Best Practices for Anti-Racism in Education

a. Research effective anti-racism practices in schools to reduce discrimination and support the well-being of Aboriginal and Torres Strait Islander and other negatively racialised youth. Studies highlight that racism in educational settings affects youth development and academic success.

7. Examine the Influence of Public Health Campaigns

a. Evaluate public health initiatives' effectiveness in reducing racism and promoting inclusivity for Aboriginal and Torres Strait Islander and other negatively racialised groups. Public health theories suggest that well-targeted campaigns can shift societal attitudes and support marginalised communities.

8. Study Culturally Tailored Mental Health Interventions

a. Research culturally responsive mental health interventions for Aboriginal and Torres Strait Islander and other negatively racialised populations to counteract stigma and promote engagement. Evidence indicates that culturally responsive approaches improve mental health outcomes by addressing specific community needs.

Key Terms and Definitions

Acculturative Stress	The psychological and emotional strain experienced by individuals navigating the process of adapting to a new culture, often stemming from challenges such as language barriers, cultural misunderstandings, prejudice or discrimination. This stress can manifest as anxiety, depression, or feelings of isolation and is particularly common among migrants and refugees.
Allostatic Load	The cumulative physiological impact of chronic stress exposure, resulting from repeated activation of the body's stress response systems. It is linked to health conditions such as hypertension, cardiovascular disease, and diabetes, often exacerbated by social determinants of health like racism, poverty or insecure housing.
Apprehended Discrimination	An expectation that a person from a marginalised group will experience discrimination that leads to avoidance behaviours, such as not seeking health care or non-disclosure of personal or health information
Cultural Alienation	A feeling of estrangement or disconnection from one's cultural heritage or community, frequently caused by pressure to assimilate into a dominant culture. This can lead to a loss of cultural identity and affect mental health, as individuals may feel they no longer fully belong to either their heritage culture or the dominant culture.
Cultural Dissonance	The psychological discomfort or tension that arises when there is a mismatch between an individual's cultural values, beliefs or behaviours and those of the dominant culture. This can affect an individual's sense of identity and belonging, often resulting in stress.
Ethnocentrism	The belief that one's own culture, values or way of life is superior to those of others, often leading to prejudice or discrimination against cultures perceived as different or inferior. Ethnocentrism can manifest in attitudes, policies and practices that devalue or marginalise other cultures, particularly in multicultural settings.
Intersectionality	A theoretical framework for understanding how multiple social identities—such as race, gender, sexuality, class, and disability—intersect to shape an individual's experiences of privilege or discrimination.
Microaggression(s)	Brief, subtle, and often unintentional discriminatory comments, behaviours or environmental cues that reinforce stereotypes or prejudice against marginalised groups. Examples include asking a person of colour, "Where are you really from?".

Minority Stress; Proximal Minority Stress	Minority stress refers to the unique stressors experienced by individuals in marginalised groups, such as racism, homophobia or transphobia. Proximal minority stress specifically relates to internal experiences, such as the fear or anticipation of discrimination, internalised stigma or the emotional toll of concealing one's identity.
Racism (Covert)	A subtle form of racism that is often indirect or disguised, making it harder to identify. Examples include being passed over for a promotion without clear reasons or perpetuating stereotypes through humour or coded language that reinforces inequality.
Racism (Interpersonal)	Acts of discrimination, prejudice or hostility that occur in interactions between individuals based on race. Examples include racial slurs, exclusion from social or professional opportunities or being treated unfairly due to stereotypes.
Racism (Structural)	A form of racism embedded in societal norms, practices and institutions that systematically disadvantages certain racial groups while privileging others. Examples include historical land dispossession of Aboriginal Peoples or policies that disproportionately disadvantage negatively racialised communities.
Racism (Symbolic)	Racism expressed through beliefs or attitudes that justify and perpetuate inequality by reinforcing stereotypes. It often appears in socially acceptable forms, such as opposing measures aimed at reducing racial disparities by arguing they provide "unfair advantages."
Racism (Systemic)	The history, ideology, culture and interactions of institutions and policies that work together to perpetuate inequity. It describes the way in which institutions and structures fail to provide adequate service provision and equal opportunities to people because of their racial or cultural background. Systemic racism is responsible for certain communities experiencing poor life outcomes, lower pay, and less opportunities for advancement within leadership positions.
Weathering Effect	Describes an accelerated physical and mental health decline caused by prolonged exposure to chronic stressors, such as racism. This phenomenon disproportionately affects marginalised groups, contributing to earlier onset of chronic illnesses and reduced life expectancy.

Introduction

Background

Racism is recognised as a critical social determinant of health that underpins stark disparities in health outcomes and access to health and social care services across racial and ethnic groups (Hamed et al., 2022; Paradies et al., 2015). In Australia, systemic racism remains a force that shapes the experiences and outcomes of marginalised groups, particularly Aboriginal and Torres Strait Islander Peoples and people from other negatively racialised communities (Bastos et al., 2018; Gatwiri et al., 2021) This scoping review, commissioned by the Australian Human Rights Commission (AHRC), seeks to comprehensively analyse existing literature on the health impacts of racism in Australia, with the ultimate goal of contributing evidence-based recommendations to the National Anti-Racism Framework. Through an in-depth examination of available literature, this review aims to highlight how racism influences health outcomes and access to healthcare. The results of this scoping review aim to provide a foundation for addressing health inequities that stem from entrenched discriminatory practices within society in general and healthcare systems specifically. It furthermore aims to highlight protective factors and best-practice examples as foundations for recommendations.

This review is anchored in the AHRC's broader initiative to counter systemic racism through a unified, society-wide approach. The Commission's consultations with stakeholders across Australia have highlighted racism as a critical barrier to equitable health access and quality of care (Australian Human Rights Commission, 2023a). Experiences of discrimination within healthcare settings not only diminish access to essential services but also cause additional psychological and social harm, compounding the disadvantage experienced by already marginalised communities (Brondolo et al., 2011). Aboriginal and Torres Strait Islander peoples, for example, face a legacy of historical injustices in Australia that continue to impact their health and wellbeing, including intergenerational trauma resulting from policies such as forced child removals and the suppression of languages, traditions and culture (Sherwood & Geia, 2014; Vivian & Halloran, 2022). Similarly, other negatively racialised people navigate challenges such as acculturative stress and cultural alienation, which are intensified by discrimination within society as well as the healthcare and other social services sectors (Ikafa, 2015; Liu, 2023).

Mapping the existing evidence on racism's impacts on health outcomes and healthcare access within Australia, this review provides insights into the structural and interpersonal mechanisms that drive health disparities. The outcomes of this research aim to inform public education, advocacy and policy efforts aimed at dismantling discriminatory practices in healthcare and promoting culturally safe and inclusive services. The aim of this review is not only to contribute to a scholarly understanding but to provide actionable insights that can support meaningful and lasting change.

Conceptualising Racism

Racism, though often framed as individual acts of prejudice or discrimination, is a complex social phenomenon embedded within the structures of societies. Scholars, including Bonilla-Silva, have argued that racism should be conceptualised as a structural construct, operating beyond isolated instances of bias to encompass broader institutional and systemic forces that marginalise certain groups over time (Bonilla-Silva, 2021). Bonilla-Silva's definition, which sees racism as a social formation at the intersections within the economic, social, and political aspects of society, highlights the historical processes of racialisation that categorise and hierarchically order groups (Bonilla-Silva, 2015). This understanding of racism and its complexity helps to understand how social systems cause, maintain and reproduce racial inequalities in ways that persist throughout societal structures, such as healthcare, education, and criminal justice, where marginalised groups, within the Australian context particularly Aboriginal and Torres Strait Islander Peoples and other negatively racialised people and communities, experience sustained systemic disadvantages.

Understanding racism requires distinguishing its various forms, since these present distinct challenges and impacts. At an individual level, racism manifests in personal interactions, often visible through derogatory language, hostile actions, or exclusionary behaviours directed towards individuals based on their actual or perceived racial or ethnic background (Clair & Denis, 2015). Part of this is also more subtle racist behaviours, also known as covert racism or everyday racism, which involve attitudes, actions, or policies that perpetuate racial stereotypes or discrimination in indirect or understated ways (Gordon & Around Him, 2024; Prince, 2024). An example of subtle racism is a teacher's assumption that a student of a particular racial background is less likely to excel in advanced coursework and subtly discourages them from enrolling, despite an otherwise strong academic performance. However, beyond these visible expressions, racism operates on systemic and institutional levels, embedding biases within societal and organisational policies, cultural norms and resource allocation practices that systematically disadvantage racialised groups (Goings et al., 2023). Institutional racism, also referred to as systemic or structural racism, is also present in health services, where policies and practices inadvertently or – in some cases – deliberately favour majority groups, resulting in unequal access, distribution, outcomes and quality of care for Aboriginal and Torres Strait Islander Peoples and other negatively racialised people and communities (Elias & Paradies, 2021). Symbolic racism and the sometimes-unconscious biases within societies that reinforce existing hierarchies further impact these communities by perpetuating a cycle of stereotypes and contributing to the normalisation of unequal treatment as part of an effectively accepted social norm (Krzyżanowski, 2020).

In Australia, the history of racism is tied to colonialism and the settler-colonial ideology, which aimed to subjugate Indigenous populations and assert White European cultural, economic and political dominance. This history established a racial hierarchy, positioning Aboriginal and Torres Strait Islander Peoples as inferior and justifying policies aimed at assimilation and segregation (Haderer, 2013). State-based racism against Aboriginal and Torres Strait Islander Peoples has been manifested in policies such as the forced removal of children (the Stolen Generations), restrictions on movement, denial of citizenship rights, and exclusion from economic and educational opportunities (Haebich, 2011; Havemann, 2005; Mercer, 2003). These policies not only disrupted Indigenous family and community structures but created intergenerational trauma that continues to affect health and wellbeing within these communities today (Menzies, 2019). Watego (2021; 2022) addresses the ways these colonial legacies continue to manifest in the healthcare system today, criticising how colonial violence is perpetuated in modern institutions, particularly within health services, where Aboriginal people are often subjected to racialised treatment and lower standards of care. She argues that Indigenous people face systemic discrimination not only as historical victims but as ongoing subjects within a state that has never reconciled its colonial past, thus creating health disparities that continue to be rooted in racism rather than cultural differences as is often debated. For other negatively racialised people and communities, particularly non-European immigrants, the White Australia Policy, which aimed at restricting non-white immigration, institutionalised a racial divide that stigmatised non-European cultures and set a precedent for social exclusion that has continued to influence these communities' experiences in Australia (Barton, 2011; Jordan, 2005).

Conceptual frameworks of racism provide an understanding of how various forms of racism interact and how these impact communities differently, including outcomes. The theory (or theories) of intersectionality, originally developed by Crenshaw (1991), are particularly relevant in examining the experiences of Aboriginal and Torres Strait Islander Peoples and other negatively racialised individuals, who often experience discrimination from multiple angles, including race, gender, religion, socioeconomic status, and, in some cases, disability or sexuality. Intersectionality demonstrates that the impacts of racism cannot and should not be understood in isolation, as individuals hold multiple identities that shape their experiences and influence how they are treated within systems such as healthcare (Turan et al., 2019). For example, for sexual minority individuals within negatively racialised populations, intersectionality highlights how racism and homophobia intersect, compounding barriers to healthcare access and intensifying health inequities. The concept of cultural safety, originally developed within Indigenous healthcare contexts, provides an additional framework that recognises the importance of creating healthcare environments where Indigenous Peoples feel respected and free from discrimination (McGough et al., 2022). This approach is important in ensuring that Aboriginal and Torres Strait Islander communities are not just included in healthcare services but are provided care that acknowledges and values their unique cultural and historical contexts. Related to the concept of cultural safety is the concept of cultural humility, which extends beyond cultural competence by encouraging healthcare providers to look introspectively, recognise their own biases and actively engage in self-reflection to understand the diverse needs of these communities better (Tascon & Gatwiri, 2020). Cultural humility is increasingly advocated within healthcare systems as a means of addressing both the structural and interpersonal aspects of racism to the benefit of all people in their care (Chang et al., 2012).

Racism and Health

The effects of racism on health are significant, and literature has demonstrated that these affect the physical, psychological, emotional, social, and spiritual dimensions of the wellbeing of both individuals and communities (Paradies et al., 2015). Racism operates as a social determinant of health, systematically disadvantaging racialised populations through restricted access to resources, including diminished quality of healthcare and increased and compounding psychosocial stress (Selvarajah et al., 2022).

Health, as defined by the World Health Organization (WHO) (1948), encompasses more than the absence of disease; it involves complete physical, mental, and social wellbeing. Although often understood as holistic, it has been criticised as perpetuating a misunderstanding of health, particularly in the context of Indigenous Peoples and other cultural understandings of health that often go beyond the definition of the WHO (Huber et al., 2011; Larson, 1996). Bok (2004), for example, proposed an updated version: "*Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease and infirmity".* In this context, it is worth noting the shift from health as a *'state'* to health as a *'dynamic state'* or process. Bok also added *'spiritual'*, specifically recognising the religious and spiritual belief aspects as well as demands for its inclusion from Indigenous cultures. This holistic definition is particularly pertinent when examining the health impacts of racism, as the cumulative effects of discrimination permeate various aspects of individuals' lives, diminishing not only physical health but also social, emotional, and spiritual wellness. This is also consistent with the definition of health by NACCHO (National Aboriginal Community Controlled Health Organisation), which adopted the following definition in their constitution (National Aboriginal Community Controlled Health Organisations, 2024):

'"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.'

Aboriginal and Torres Strait Islander Peoples and other negatively racialised people experience

racism both within healthcare systems and through broader societal structures, resulting in health disparities that are deeply entrenched and multifaceted (Dune et al., 2021).

The psychological impact of racism has been extensively documented, with research linking experiences of discrimination to heightened levels of anxiety, depression and psychological distress as well as neurobiological changes and damage (Berger & Sarnyai, 2015; Willis et al., 2021). Chronic exposure to racism can lead to race-based traumatic stress, a condition akin to post-traumatic stress disorder, which affects mental health resilience and coping mechanisms (Carter et al., 2020). In the case of Aboriginal and Torres Strait Islander Peoples, the effects of intergenerational trauma—stemming from policies of displacement, forced child removals, and cultural suppression—are compounded by ongoing experiences of discrimination, resulting in higher rates of suicide, substance use and psychological distress (Dudgeon et al., 2017; Nutton & Fast, 2015). For other negatively racialised communities, particularly recent migrants and refugees, racism exacerbates acculturative stress and the trauma previously experienced by many refugees, contributing to

mental health issues that are often unaddressed due to language barriers, lack of culturally appropriate services, and fear of discrimination within healthcare settings (Niles, 2020).

Racism has also been shown to negatively influence physical health outcomes. Research shows that discrimination correlates with higher incidences of cardiovascular disease, hypertension, and metabolic disorders (Kaholokula, 2016; Lewis et al., 2014; Moody et al., 2018). Chronic stress, driven by the anticipation and/or experience of racism, triggers physiological responses that contribute to these health issues, creating a 'weathering effect'—a term used to describe how prolonged exposure to stressors leads to premature biological aging (Geronimus, 2020). Indigenous health frameworks, which view health as inclusive of social, emotional, and spiritual wellbeing, are commonly used to demonstrate that racism disrupts essential cultural connections to community, land, and heritage, elements that are fundamental to Indigenous peoples' health (Paradies, 2016). As an example, the inability to access culturally safe and respectful healthcare services results in poorer health outcomes and decreased trust in healthcare institutions, reinforcing a longstanding cycle of health disparities (Mitchell et al., 2022). This cycle is further compounded by perceived racism or the fear of encountering discriminatory treatment, which is understood within the minority stress model as a form of proximal minority stress - stressors that are internally experienced and arise from the anticipation or internalisation of stigma and discrimination (Frost & Meyer, 2023; Rivas-Koehl et al., 2023). These proximal stressors, which include the fear or expectation of racism, contribute to heightened psychological distress and, subsequently, avoidance of healthcare services (Paradies et al., 2015). By preventing individuals from accessing essential care, proximal minority stress perpetuates health inequities and reinforces the structural barriers that maintain health disparities.

The fear of experiencing discrimination can manifest into 'apprehended discrimination' (Avery, 2018; Temple et al, 2020b) whereby people avoid situations in which they can rationally expect to encounter discrimination. Apprehended discrimination may influence a person's propensity to seek health care, or to the degree that they may disclose personal information during the health assessment and diagnostic process. Avoidance and non-disclosure of personal and health information further limits the health system's knowledge on racially marginalised groups to what members of that community are safely willing to disclose to health practitioners and researchers. This phenomenon further poses a limitation to the reach of racism research such as those sourced through a strict selection criteria used for this scoping paper.

Social sciences theories can further help in understanding how racism contributes to health inequalities and inequities. The social stress model posits that chronic stress from discrimination not only directly impacts health but also limits individuals' access to coping resources, such as supportive social networks and quality healthcare services (Berger & Sarnyai, 2015)Note>. In Indigenous contexts, the concept of 'collective resilience' is increasingly explored, where the strength and solidarity of Indigenous communities play a crucial role in mitigating the health impacts of racism (Usher et al., 2021). However, while community support can offer some protection against racism's effects, it does not eliminate the structural disadvantages faced by Indigenous and other negatively racialised people and communities in healthcare access and quality.

Methodology

The Research Team

The research team conducting this scoping review on the health impacts of racism in Australia are able to provide a critical perspective shaped by personal and professional experiences with marginalisation. Every team member identifies as either Aboriginal or culturally and linguistically diverse, grounding this project in an understanding that is informed by lived experience. The team includes Aboriginal researchers with ties to the Worimi, Barunggam, and Kuku Yalanji nations, as well as researchers from diverse cultural and linguistic backgrounds. Moreover, several team members hold intersecting identities—such as Aboriginal and Disabled, and Culturally And Linguistically Diverse (CALD) and Gay—that deepen their understanding of how overlapping forms of discrimination impact health and wellbeing. These perspectives enhance our capacity to conduct this research with cultural insight and a commitment to producing findings that resonate with the lived realities faced by marginalised communities.

Rather than introducing bias, the team's positionality strengthens the research by facilitating a nuanced and empathetic approach that might otherwise be inaccessible to those without similar lived experiences. Engaging with topics of marginalisation from within identities marginalised by society allows the team to approach the literature with an awareness of how discrimination operates on both systemic and personal levels. Indigenous team members bring insights into the ongoing impacts of colonial policies, while other team members understand firsthand the challenges of navigating healthcare systems that may not be culturally inclusive or open. These perspectives are essential for interpreting the literature with respect to both Aboriginal and Torres Strait Islander Peoples and other communities.

Incorporating researchers who themselves have experienced marginalisation and intersecting forms of discrimination enhances the research process by promoting a strength-based, rather than deficit-focused, approach. The team aims to produce findings that empower communities and highlight resilience and agency, rather than reinforcing negative stereotypes. This positionality informs a perspective that underscores the value of cultural safety, equity, and community engagement in health research.

Scoping Review Methodology

This study employs a scoping review methodology, an approach particularly suited to exploring the extent, range, and nature of evidence on a specific topic, as described by Arksey and O'Malley (2005) and further refined by Levac et al. (2010). Scoping reviews are designed to map existing literature to provide a comprehensive overview rather than a narrowly focused assessment as in systematic reviews. This method was selected because it aims for a broader examination of both academic and grey literature related to the impacts of racism on health outcomes, encompassing varied sources and disciplines. Given the multifaceted nature of racism and its diverse effects on health, particularly within the sociocultural contexts of Aboriginal and Torres Strait Islander and other negatively racialised populations, a scoping review is suited to capture complexity and identify research gaps.

Scoping reviews do not require the strict inclusion criteria of systematic reviews, allowing for the inclusion of both empirical and conceptual work, including studies that may differ in design, data collection methods, and theoretical orientation. As such, in a scoping review, the introduction and background section are commonly also significantly larger works that are an integral part of the research itself, rather than just fulfilling the purpose of introducing to a topic more generally as is common in a systematic review. This is particularly important for interdisciplinary topics such as racism, which spans health, sociology, psychology, and public policy, as well as Indigenous and cultural studies. A scoping review also provides an opportunity for identifying research gaps and inconsistencies in the literature, which is critical for informing the Australian Human Rights Commission's broader goals under the National Anti-Racism Framework.

Search Strategy

The search strategy was developed collaboratively, drawing on the expertise of team members in public health, social sciences and Indigenous studies to establish a comprehensive framework for identifying relevant literature. The search strategy was furthermore discussed with a librarian specialising in literature reviews. The principal research topic, *the impact of racism on health outcomes and healthcare access*, was operationalised into four core concepts: (1) Populations, (2) Geography, (3) Health Outcomes and (4) Racism — each of which was defined through a series of targeted keywords and Boolean search terms. For each concept, synonyms and related terms were included to ensure the search captured a broad range of studies that might address the subject under varied terminology.

Key databases were selected based on their coverage of disciplines relevant to health, including public health, allied health and medicine, psychological sciences, and social sciences, including social work and sociology. These included PubMed, selected for its comprehensive focus on public health and clinical studies; Embase, a major database in the areas of biomedical and pharmacological research; CINAHL, covering nursing, midwifery, and allied health disciplines; PsychInfo, with a focus on psychology and psychiatry; and SocIndex, relevant for social sciences, sociology, and community studies. Scopus was utilised as a broad-spectrum database to ensure inclusivity of any studies not indexed in more specialised databases. In addition, Google Scholar was used to capture potential grey literature, including reports and papers that may not appear in traditional academic databases. Including Australian Indigenous HealthInfoNet was essential to capture literature focused on Indigenous health, particularly studies that may not be indexed in other databases.

The search strategy was limited to studies published from January 2014 to October 2024 to capture contemporary data, as understandings of racism and its health impacts evolve over time. The search focused exclusively on studies involving human participants within an Australian context, ensuring that the results would be directly applicable to the unique sociocultural and historical contexts affecting Aboriginal and Torres Strait Islander and other negatively racialised populations in Australia. An example of the search strategy as executed on PubMed:

("Australian Aboriginal" OR "Torres Strait Islander" OR Aboriginal OR "Indigenous people*" OR "Native Australian*" OR "First Nation*" OR "First Australian*" OR "Ethnic minorit*" OR "Racial minorit*" OR "Culturally and linguistically diverse" OR CALD OR "Racially diverse" OR Immigrant OR Refugee OR "Foreign-born" OR "Diverse ethnic group" OR "Ethnic diversity" OR Bicultural OR Multinational* OR "Cross-cultural" OR "African people*" OR "Asian people*" OR "Black people*" OR "Caribbean people*" OR "Middle Eastern people*" OR "Arab people*" OR Indians* OR "South-Asian people*" OR "South-American people*" OR Hispanic OR "Pacific Islander*" OR "Racialised Person*" OR "Racialized person*" OR "People of Colour" OR "Marginalised Racial Group*" OR "Marginalized Racial Group*")*

AND

(Australia OR "New South Wales" OR Victoria OR Queensland OR "South Australia" OR "Western Australia" OR Tasmania OR "Australian Capital Territory" OR "Northern Territory" OR "Christmas Island" OR "Norfolk Island" OR "Cocos Island" OR "Keeling Island" OR Sydney OR Melbourne OR Brisbane OR Canberra OR Adelaide OR Darwin OR Perth OR Hobart)

AND

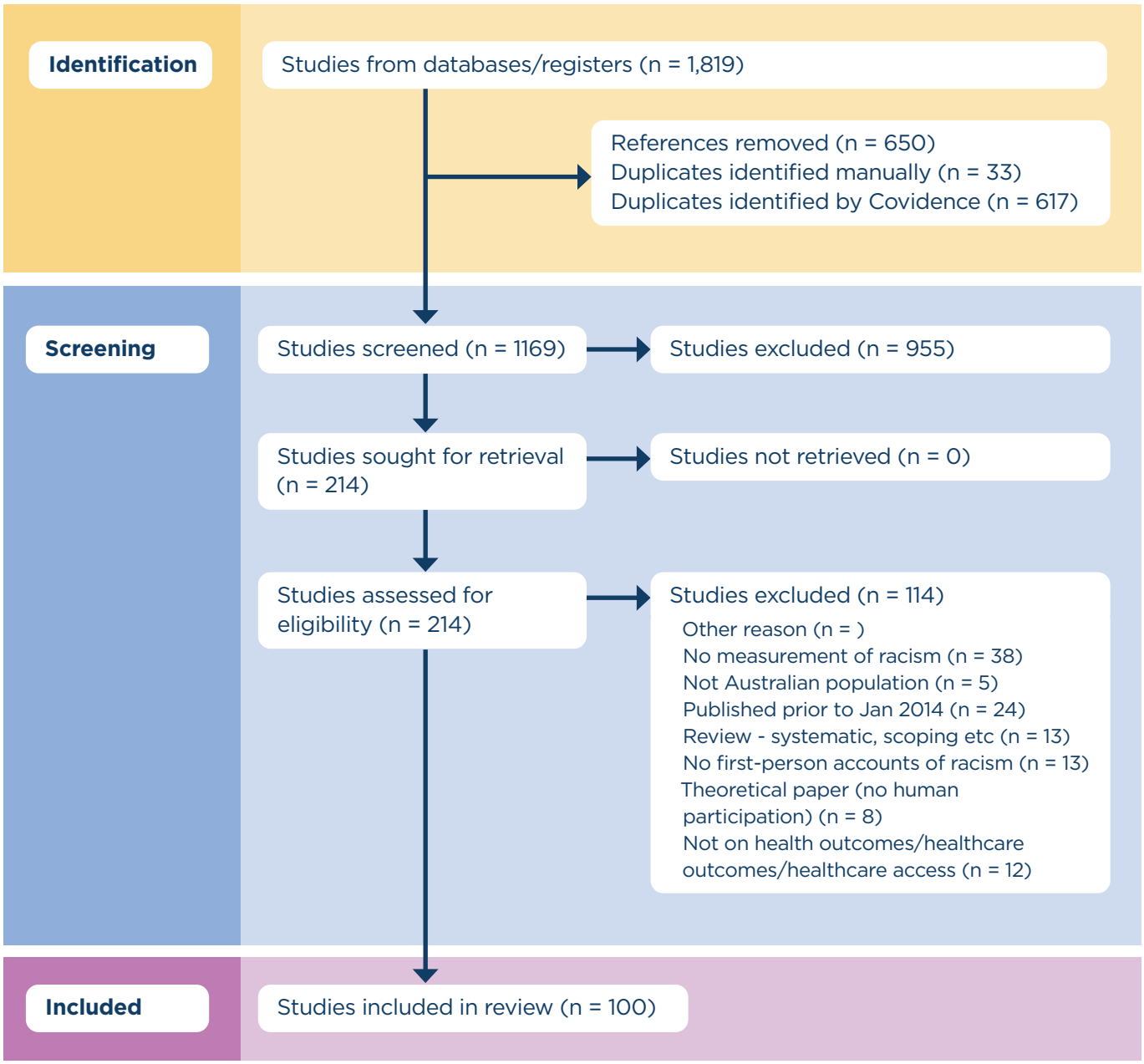
("Health Outcomes" OR "Health Disparities" OR "Health Inequalities" OR "Health Inequity" OR "Health Equity" OR "Health Care Disparities" OR "Healthcare Outcomes" OR "Healthcare Inequalities" OR "Healthcare Inequity" OR "Healthcare Equity" OR "Socioeconomic Disparities in Health" OR "Health Status Disparities" OR "Adolescent Health" OR "Child Health" OR "Infant Health" OR "Men's Health" OR "Mental Health" OR "Mental Wellbeing" OR "Substance Use" OR "Women's Health" OR "Occupational Health" OR "Oral Health" OR "Psychological Health" OR "Psychological Wellbeing" OR "Rural Health" OR "Reproductive Health" OR "Sexual Health" OR "Sexual Wellbeing" OR "Maternal Health" OR "Healthcare Access" OR "Healthcare Treatment" OR "Health Services Accessibility" OR "Spiritual

Health" OR "Spiritual Wellbeing") AND (Racism OR Discrimination OR "Racial Bias" OR Prejudice OR "Racial Inequality" OR "Racial Injustice" OR "Racial Inequity" OR "Racial Profiling" OR Microaggression OR "Anti-racism" OR Xenophobia* OR Colourism OR Colorism OR "Anti-Blackness" OR "White Privilege" OR Ethnocentrism)*

Citations identified in the search process were loaded onto Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia) for screening and management.

The search and selection process consisted of three phases to ensure a rigorous selection of relevant studies. In Phase 1, titles and abstracts were screened independently by two reviewers to determine initial relevance based on keywords and concepts mentioned in titles and abstracts. Discrepancies between reviewers were resolved by discussion or, where necessary, by a third reviewer. Phase 2 involved a full-text review conducted by two independent reviewers, using the same approach to conflict resolution. Phase 3 included data extraction conducted by one reviewer, with a random check of 10% of the data entries by a second reviewer to confirm consistency and accuracy.

Figure 1: Article Selection Process



Inclusion and Exclusion Criteria

Although inclusion and exclusion criteria do not have the same weight and importance in a scoping review compared to a systematic review, these are still necessary for an appropriate conduct of a review of relevant literature. Inclusion and exclusion criteria were established to ensure relevance to the scope and aims of the study, focusing on research that addresses the relationship between racism and health outcomes and access to healthcare for Aboriginal and Torres Strait Islander Peoples and other negatively racialised populations in Australia. Each criterion was selected to ensure alignment with the research objectives.

Inclusion Criteria:

1. Research conducted on an Australian population. This ensures the findings are relevant to Australia's unique sociocultural and historical context.
2. Involves human participants. This limits the scope to studies providing data on human health outcomes, ensuring direct relevance to the populations of interest.
3. Focuses on Australian Indigenous People and/or other negatively racialised populations. These groups are the primary focus of this scoping review, as they experience distinct and systemic impacts of racism on health.
4. Reports on racism and its impact on health outcomes, including healthcare access. This ensures studies are directly addressing the relationship between racism and health.
5. Written in English. Language inclusion criteria ensure accessibility for all research team members and maintain consistency in interpreting findings.
6. Published between January 2014 to October 2024. The timeframe is restricted to recent literature, reflecting current understanding and policies related to racism and health.

Exclusion Criteria:

1. Does not focus on an Australian population. Non-Australian studies are not relevant to the context and specifics of racism in Australia.
2. Multi-country samples without subgroup analysis for Australian participants. Such studies cannot provide insights specific to Australian populations unless they include a detailed breakdown of Australian data.
3. Theoretical papers without human participation. Ensures the inclusion of empirical studies focused on human health outcomes rather than theoretical discourse without application.
4. Studies involving non-targeted populations without subgroup analysis. General studies that do not separate data for the targeted populations are unable to inform the specific research questions.
5. Does not report associations between racism and health outcomes or access to healthcare. Only studies linking racism with health impacts are relevant to the research objectives of this study.

The scope of this review is narrow with its emphasis on empirical evidence directly linking racism to health outcomes and healthcare access, which excludes many theoretical discussions and historical contextualisations. While theoretical frameworks and historical analyses provide crucial insights into the origins and systemic nature of racism, the inclusion of such studies would broaden the scope beyond what is feasible for this review's practical objectives; however, these have been integrated throughout the review to further contextualise our findings.

Terminology Used in the Scoping Review

For the purposes of this report, we use the term *Aboriginal and Torres Strait Islander Peoples*, while researchers on the team additionally use the term *Indigenous*. This terminology was chosen to align with the preferences expressed by contributors and reflects an inclusive approach to acknowledging the diverse identities within these communities. We recognise the distinct cultural, historical and linguistic identities of Aboriginal and Torres Strait Islander Peoples and the importance of addressing them with respect and specificity. This choice aims to uphold clarity and cultural sensitivity throughout the report.
We have otherwise used the term 'other negatively racialised' people. The summaries included in the data extraction tables uses the terminology adopted by the authors of the included articles.

Summary and Discussion of Included Literature

A total of N = 1,819 studies were identified through database and register searches (*see Figure 1*). After removing n = 650 duplicates, n = 1,169 studies proceeded to the screening stage. During screening, n = 955 studies were excluded, leaving n = 214 studies assessed for eligibility. Of these, n = 114 were excluded based on criteria such as absence of racism measurement (n = 38), non-Australian populations (n = 5), publication before January 2014 (n = 24), being reviews (n = 13), lack of first-person accounts of racism (n = 13), theoretical focus without human participation (n = 8), and absence of focus on health or healthcare outcomes (n = 12). Ultimately, n = 100 studies were included in the review, focusing on racism and its impacts on health or healthcare access in Australian populations. A detailed breakdown of each study, including a summary, can be found in Table 1 (*see Appendix 1*).

Study Characteristics

Study Designs

The studies included in this review showed diverse approaches and emphases in research design. Research designs were influenced in many cases by the needs of Indigenous and other negatively people and communities , for example, Agu et al. (2016), in their study exploring barriers and enablers to accessing sexual health services Sub-Saharan African, Southeast Asian, and East Asian migrants, stated that the multilayer qualitative approach for their study was purposefully chosen to facilitate the comprehension and explanation of the multilayered social realities and lived experiences of participants. Quantitative cross-sectional designs are the most common, representing nearly half of the studies (n = 46). Cross-sectional studies are often preferred for their efficiency and cost-effectiveness in capturing data from larger samples, although the data they capture is commonly described as static, given the limited capability to capture unique experiences. Quantitative longitudinal studies were used in 18 studies – this research design is commonly perceived to be valuable for assessing changes over time, which is particularly relevant for understanding the long-term impacts of discrimination on health outcomes and access to health services. Qualitative study designs were also present (n = 26), allowing researchers to gain in-depth insights into unique participant experiences, a particular need for research on marginalised populations where nuanced individual perspectives on health access and social determinants are important. Mixed-methods approaches were present in ten studies, often perceived to reflect a balanced approach by combining quantitative and qualitative methods to offer more comprehensive insights. Participant numbers varied widely in studies, with sample sizes ranging from as few as 5 to over 12,000 participants, reflecting the diverse scales and scopes of studies in this field with qualitative studies commonly having lower sample sizes than quantitative studies, consistent with expectations and best-practice guidelines.

Differences exist in study designs between research focusing on Aboriginal and Torres Strait Islander Peoples and those on other negatively racialised people; some patterns emerge. Indigenous-focused studies were more likely to utilise qualitative methods, such as interviews, yarning and participatory approaches, which are culturally responsive and allow for an in-depth exploration of Indigenous experiences. This preference aligns with the need for culturally safe research that honours Indigenous voices, often involving community engagement and Indigenous researchers. Indigenous studies included a balanced mix of cross-sectional (quantitative) and longitudinal designs but leaned heavily towards qualitative approaches to capture the community's nuanced experiences with health, discrimination and social determinants. Studies on other populations were more diverse in their methodological approaches, often using both quantitative cross-sectional and longitudinal designs to analyse trends over time. This focus aligns with the broader urban setting and varied backgrounds within these communities, where a quantitative approach is suited for capturing

specific health indicators, social integration, and employment-related issues across different cultural groups. However, these studies also incorporated qualitative methods to investigate complex topics such as mental health stigma, workplace discrimination, and service access challenges, reflecting the layered experiences of discrimination among these populations. Some studies have incorporated an intersectional lens to examine the overlapping challenges faced by both Aboriginal and Torres Strait Islander Peoples and other negatively racialised people who also identify with sexual minorities or who are living with disabilities, particularly the compounded effects of racism and stigma related to sexual orientation.

Another notable difference is that studies focused on Aboriginal and Torres Strait Islander populations more commonly used longitudinal designs to assess long-term impacts, particularly in relation to systemic discrimination and health outcomes. This focus on longitudinal methods likely reflects the need to understand historical and ongoing impacts of systemic issues on Indigenous communities. In contrast, studies on other negatively racialised populations were less frequently longitudinal and often focused on capturing current snapshots of health, employment, and social integration issues, reflecting participants' generally more recent migration backgrounds and urban-based challenges. These differences underscore the tailored approaches needed to address the unique experiences and systemic challenges faced by these populations in Australia.

Population Focus

Of the 100 included studies, n = 58 studies focused on Indigenous Australians, while n = 42 addressed other negatively racialised populations. Geographically, studies spanned the entirety of Australia, with most (n = 48) covering multiple regions or providing a national perspective. New South Wales (n = 14), Victoria (n = 13), Queensland (n = 11), and South Australia (n = 8) were the most frequently represented states. Indigenous-focused studies were more likely to take place in regional and remote settings than studies on other populations, with these locations crucial for examining accessibility and cultural safety in health services, which remain major issues in these areas. In contrast, studies on other negatively racialised populations often centre around urban settings, reflecting the higher urban concentration of Culturally and Linguistically Diverse communities.

Settings

Settings other than geographic regions also highlight distinctive focuses between populations. Community health services were frequently used (n = 21), followed by hospitals (n = 18) and Aboriginal Medical Services (AMS) (n = 11), which were primarily settings for Indigenous-focused research. This reflects a reliance on culturally safe environments such as AMSs and a focus on primary healthcare, which is often the first line of care for Aboriginal and Torres Strait Islander communities. In contrast, studies on other populations more likely emphasised settings in workplaces, employment contexts, and schools, indicating a concern with how systemic and interpersonal discrimination in social institutions impacts health outcomes. Prisons were another common setting (n = 8), particularly in Indigenous research, underscoring the overrepresentation of Indigenous Australians in the justice system and the critical need to understand health inequities in detention environments.

These differences in geographical and contextual settings, as well as differences between settings, are indicative of the broader socio-economic realities faced by Aboriginal and Torres Strait Islander and other negatively racialised populations. Indigenous Australians, who disproportionately live in regional or remote areas, require research that addresses the unique barriers to healthcare and the cultural sensitivities that impact their health outcomes. Other communities, primarily urban-based, face distinct challenges in accessing culturally competent services and navigating healthcare systems within a multicultural urban framework.

Definitions and Measurements of Racism

Studies showed distinct approaches to categorising and understanding various forms of racism. A total of 14 studies specifically addressed interpersonal racism, defined by direct experiences of prejudice or discrimination in social, workplace, or healthcare settings. This form of racism was often documented through self-reports of unfair treatment, and studies frequently linked these experiences to negative health outcomes, such as psychological distress and avoidance of services. Systemic racism was the focus in eight studies, which explored how institutional and structural biases disadvantage marginalised groups, particularly Indigenous Australians. These studies often lack specific tools to quantify systemic racism but emphasised its impact on access to care and broader social inclusion. Additionally, five studies used combined approaches to address both interpersonal and systemic racism. These studies provided a nuanced view by capturing how individual experiences of discrimination relate to broader institutional frameworks. Finally, non-specific forms of racism were examined in two studies that did not distinctly categorise the type of discrimination. These studies focused more broadly on the prevalence of discrimination without specifying interpersonal or systemic dimensions, providing general insights rather than precise categorisation.

Some studies used measures aimed at interpersonal racism, often defined through personal, direct encounters of prejudice in environments such as healthcare, workplaces, or public spaces. Tools like the Measure of Indigenous Racism Experiences (MIRE), developed by Paradies and Cunningham (2008), categorise racism into varying intensities by evaluating the number of settings in which participants experience discrimination over time. This approach to measurement underscores the prevalence and frequency of interpersonal racism and its potential effects on individuals' wellbeing. The Everyday Discrimination Scale (EDS) was another frequently used tool, designed to assess frequent and subtle experiences of racism, such as experiencing less respectful treatment or routine insults linked to racial or ethnic identity. The scale is widely applied to quantify recurring discriminatory interactions, making it particularly relevant to studies focusing on psychological impacts, especially within marginalised populations (Lawrence et al., 2022).

Using standardised measures offers both benefits and challenges in the research context, particularly when applied to diverse communities in the context of racism research. Standardised instruments allow for consistency across studies, making it more effective to compare findings across studies and allowing for the broad tracking of patterns of racism's impact on health and wellbeing over time (Grigg & Manderson, 2016). However, these tools may not fully capture the nuanced experiences of different communities, as racism manifests uniquely across cultural, historical, and social contexts (Greenfield et al., 2021). Some studies selected specific questions from one or more tools, rather than utilising the full validated instruments. In research with diverse populations, such measures must be sensitive to cultural differences and specific lived experiences; otherwise, they risk oversimplifying or overlooking key aspects of discrimination. Co-designing these instruments with community members is essential, as it ensures that the questions reflect real, context-specific experiences of racism and are more likely to resonate with participants (Wright et al., 2021). Community involvement in developing standardised tools like 31-item Measure of Indigenous Racism Experiences (MIRE) can also enhance trust, cultural appropriateness, and accuracy, making the data collected more reflective of the actual challenges faced by marginalised groups and ultimately leading to more impactful and informed outcomes. The development of MIRE (Paradies & Cunningham, 2008) is an example that demonstrates the importance and impact of co-design in research, involving an initial focus group with Indigenous professionals to identify important dimensions of racism, followed by confirmatory focus groups to refine the instrument's relevance and clarity. This process helped to ensure cultural accuracy by engaging Indigenous community members directly in shaping the tool, which addresses interpersonal racism, responses, internalised racism, and systemic awareness. The MIRE uses flexible rating scales that let people share how often they experience racism based on their personal views and unique experiences, without limiting them to a specific time period.

Nine studies also examined systemic racism, which is embedded within institutions and structural frameworks rather than solely within personal interactions. Studies assessing systemic racism often forego specific scales in favour of broader

definitions and qualitative narratives that capture lifelong or long-term institutional exposures (Wojnicka & Nowicka, 2024). This approach is particularly relevant for exploring discrimination in settings like healthcare, education, or social services, where embedded biases can hinder access to quality care or services, reflecting broader patterns of social inequity.

Another eight studies employed self-reported measures without structured scales, relying instead on participants' recognition of unfair treatment or discrimination related to race or ethnicity. This approach offers a simpler approach to recording experiences and provides a binary response format, such as a simple "yes" or "no" making it effective in studies where accessibility and participant understanding are priorities. These self-reported experiences are especially useful in contexts where discrimination impacts younger populations, capturing formative encounters that can influence lifelong perspectives. However, using self-reported measures with a binary response format may introduce biases by oversimplifying complex experiences of discrimination. Forced binary choices may also lead participants to exclude nuances, as they cannot express the frequency, severity, or context of discriminatory incidents (Bar-Hillel et al., 2014). This limitation can be particularly restrictive for younger participants or those with varied experiences across different settings, as it prevents them from fully capturing how discrimination impacts their lives. As such, binary responses may underestimate the extent and impact of discrimination.

A combined approach using both quantitative scales and qualitative methods would be an appropriate way to create a more comprehensive picture of racism and discrimination. For instance, studies that pair the Everyday Discrimination Scale with in-depth interviews would allow participants to provide both frequency-based and contextual information. This allows researchers to capture not only how often discrimination occurs but also its perceived motivations and intentions, the contexts in which it unfolds, and the emotional impact on individuals. Such combined methods provide a holistic understanding of the impact of racism, especially when interpersonal discrimination is compounded by systemic barriers. However, such an approach has not been taken by any of the included studies.

Some studies focused on intersecting forms of discrimination provide further depth to the understanding of how racism operates across multiple dimensions of identity. Some studies explicitly examined these intersections, such as research on Aboriginal and Torres Strait Islander LGBTQ+ individuals, (McCormack et al., 2024), older people (Temple et al., 2019) or those living with a disability (Temple, Wong, et al., 2020).

Racism and Health Outcomes

The following sections examine the health impacts of racism and discrimination on both Aboriginal and Torres Strait Islander Peoples and other negatively racialised people within Australia. We highlight the overall findings from the literature using examples from included studies and contextualise these findings further with theoretical frameworks; we additionally work to highlight the relationships between different aspects of racism and health outcomes.

Non-Indigenous People who are Negatively Racialised and their Communities

The retrieved literature shows that racism and discrimination against non-Indigenous people who are negatively racialised and their communities, particularly those with refugee backgrounds, are deeply entrenched within many social, institutional and structural frameworks in Australia. These forms of discrimination present as both interpersonal and systemic barriers that significantly impact these people and communities across multiple domains, including employment, healthcare, education and social spaces. The intersectional and cumulative nature of these experiences often intensifies adverse health outcomes, leading to heightened psychological distress, poorer physical health and restricted or limited access to essential health and health-related services. Studies on these communities were conducted almost exclusively in urban settings making it impossible to draw conclusions about differences in experiences between urban and regional/remote communities.

Interpersonal Discrimination and Mental Health Outcomes

Interpersonal discrimination acts as a significant barrier to inclusion and psychological health. Research on African refugees in South Australia, for example, shows that approximately 22% of respondents have experienced racism since their arrival, with 90% perceiving this discrimination as directly impacting their health (Ziersch et al., 2020). This aligns with the theoretical framework of *"everyday racism"* where repeated discriminatory encounters impose chronic stress that erodes mental resilience over time (Storey, 2019). Such interpersonal discrimination, frequently encountered in everyday settings like workplaces or public spaces, has been shown to correlate with heightened psychological distress, anxiety, and depressive symptoms (Afsharian et al., 2021). Afsharian et al. (2021) identify a statistically significant correlation ($r = -0.35$, $p < 0.01$) between workplace harassment and psychological distress, particularly for individuals lacking social support networks, a fact particularly common for recently arrived migrants and refugees. These findings align with another included study by Ferdinand et al. (2015) which found that frequent encounters with discrimination led to increased psychological distress among these populations. These findings suggest that discrimination impacts not only the immediate mental health of people but also weakens their long-term emotional resilience and social cohesion, limiting their ability to establish or access supportive social networks.

Discrimination in the Workplace and Its Psychosocial Consequences

Workplaces are sites of recurring discrimination for non-Indigenous negatively racialised individuals, especially for refugees, with considerable implications for both mental health and economic stability. Research indicates that 40-52% of refugee workers report encountering ethnic discrimination within Australian workplaces, often manifesting as derogatory remarks, exclusion, or biased treatment based on ethnicity or cultural background (Daly et al., 2018). This discrimination impacts employees in multiple ways such as lower job security, limited control over working conditions and reduced workplace support. These combined factors further intensify the psychological burden of discrimination. The theoretical framework of *"job strain"* is particularly helpful in this context, as high-demand, low-control work environments heighten stress responses for individuals, resulting in poorer mental health outcomes and diminished job satisfaction (Afsharian et al., 2021). The job strain model is further validated by Bastos et al. (2018), who documented the compounded stress of low-control, high-demand environments for individuals, correlating with worsened mental health and economic insecurity. This discrimination also constrains social determinants of health, such as economic stability and occupational mobility, perpetuating cycles of socio-economic disadvantage and generating long-term effects on both mental and physical health outcomes.

Case Study

Hala Abdelnour, a professional of Lebanese heritage, has experienced both overt and covert workplace discrimination, exemplifying the challenges faced by Culturally and Linguistically Diverse individuals in Australian workplaces. More than a decade ago, while working as a social worker, Ms. Abdelnour was confronted with a discriminatory remark from her manager, who asked, "Why are the Lebos destroying Coburg and Broadmeadows?" This question, rooted in cultural stereotyping, placed an undue burden on her to justify her heritage.

In a more recent role, she encountered further discrimination when colleagues questioned her request for Good Friday leave, presuming she was not Christian due to her Middle Eastern background. Such assumptions led to a prolonged discussion over her faith rather than a straightforward leave approval process. Additionally, Ms. Abdelnour has reported instances of being silenced in meetings, overlooked for promotions, and subjected to gaslighting.

Source: ABC News (Khadem, 2022)

Systemic Discrimination in Healthcare and Barriers to Access

Healthcare settings further exacerbate the challenges faced by these populations, where systemic discrimination often results in delayed care, substandard treatment and unmet health needs. In North Queensland, a study by Au et al. (2021) shows that language barriers, lack of interpreter services and perceived biases among healthcare providers create significant obstacles for refugees seeking care. Refugees requiring interpreters, for instance, report prolonged wait times leading to delayed diagnoses and worsening health outcomes. Additionally, some participants expressed concerns over privacy breaches when using interpreters, discouraging them from disclosing critical medical information, which ultimately compromises the quality of care received. Additionally, Agu et al. (2016) discuss how stigma-related barriers deter engagement in healthcare, especially mental health services, as cultural stigma around healthcare access discourages individuals from seeking help. These findings align well with broader healthcare research, which suggests that systemic barriers create cumulative psychological burdens, reinforcing a distrust of healthcare providers and increasing mental health risks (Khatri & Assefa, 2022). Such barriers discourage engagement with healthcare services can contribute to untreated health conditions and poorer long-term health outcomes.

Intersecting forms of racism significantly impact communities in Australia, particularly those from refugee backgrounds. A study on African migrants with refugee backgrounds in South Australia demonstrated how systemic and interpersonal racism, coupled with gendered dynamics, created barriers to mental health services.

Case Study

In Australia, patients from Culturally and Linguistically Diverse backgrounds often encounter significant challenges within the healthcare system, including language barriers, cultural misunderstandings, and limited access to culturally appropriate support services. These obstacles can lead to delays in diagnosis and treatment, adversely affecting patient outcomes. To address these issues, initiatives such as the establishment of support groups tailored for multicultural cancer patients have been implemented (e.g., Sister Cancer Support in Sydney). These groups provide a platform for sharing experiences, offering emotional support, and disseminating vital information about navigating the healthcare system. By fostering a sense of community and understanding, such initiatives aim to improve the overall well-being and treatment experiences of Culturally and Linguistically Diverse cancer patients, ensuring they receive equitable and effective care.

Source: ABC News (Timms, 2021)

Educational Discrimination and Developmental Impact on Youth

Educational settings are also spaces in which negatively racialised people, particularly young people, experience racial discrimination, with significant implications for their psychological and developmental well-being. A study among 4,664 students aged 10-15 years old from NSW and Victoria (N. Priest et al., 2020) reports that African and Middle Eastern students frequently

experience verbal harassment, exclusion, and racial stereotyping from both peers and, occasionally, educators. Racial discrimination within educational settings, as Islam et al. (2022) found, negatively impacts young people's psychological well-being, with increased symptoms of anxiety and behavioural issues due to bullying. These experiences correlate with increased symptoms of anxiety, depression, and decreased self-esteem, as students navigate the dual challenges of academic performance and social exclusion. As educational institutions serve as key environments not only for formal but also social learning, discrimination within these settings disrupts students' ability to engage positively with peers and academic responsibilities, which, in the long-term, impair social and emotional development with significant impacts on their health and wellbeing. Over time, educational discrimination limits academic outcomes and restricts opportunities for higher education or skilled employment, reinforcing broader socio-economic disadvantages (N. Priest et al., 2020).

Stigma, Mental Health Discrimination and Barriers to Healthcare

The stigma associated with mental health conditions, coupled with racial discrimination in healthcare access, present challenges for communities, particularly in accessing mental health services. Radhamony et al. (2023) document that both direct and vicarious experiences of discrimination discourage mental health service use among individuals, as fears of stigma and expectations of culturally insensitive treatment are significant barriers. Participants in the study describe how negative perceptions of mental health conditions within their communities and healthcare systems discourage them from seeking help, resulting in prolonged isolation and worsening mental health symptoms. Fauk et al. (2021) highlight that stigma and discrimination, particularly against mental illness in these communities, act as substantial barriers to healthcare access. These barriers are reinforced by systemic racism, as healthcare systems are often not designed to provide culturally sensitive care, thereby neglecting the specific needs of negatively racialised communities. Agu et al. (2016) also support these findings, showing that stigma-driven reluctance in seeking mental health services leads to prolonged isolation and worsened mental health symptoms among individuals. This reluctance is often intertwined with systemic issues and presents a cycle of stigma, actual discrimination and expected discrimination. This reinforces mental health access barriers, creating a cumulative impact on mental health outcomes.

Aboriginal and Torres Strait Islander Peoples and Their Communities

The extent of racism and discrimination experienced by Aboriginal and Torres Strait Islander populations in the retrieved literature, is substantial, permeating various aspects of everyday life and impacting health outcomes directly and indirectly. Racism experienced by Indigenous people and their communities manifests both interpersonally, through interactions in public and private settings, and systemically, via institutional policies and practices that continue to sustain inequality.

Interpersonal Racism and Mental Health

Interpersonal racism affects a significant portion of Indigenous Australians, with particular prevalence among individuals facing additional vulnerabilities. For example, Temple, Wong et al. (2020) found that Aboriginal and Torres Strait Islander individuals with disabilities report high rates of racism, with 42% experiencing discrimination compared to 32% among their non-disabled peers. This interpersonal discrimination often manifests as name-calling, being ignored, or being refused service, which not only isolates individuals but also contributes to stress and avoidance of essential services, particularly healthcare and government services. Such discriminatory encounters increase psychological distress, which, as noted by Thurber et al. (2022), represents nearly half (49.3%) of the overall burden of mental health distress among Aboriginal and Torres Strait Islander participants, corroborating the findings of Temple et al. (2020), which emphasise the impact of discrimination on mental health, especially for Indigenous people with disabilities. Chalmers, Austen, and Griffiths (2022) illustrate how racism and colourism intersect with gender and sexual identity to shape Indigenous women's experiences. Participants described feeling invalidated within their own communities based on their skin tone, particularly fair-skinned women, while darker-skinned women faced exclusion and stigma rooted in societal beauty standards. These dynamics amplified

psychological distress, underscoring how the intersection of race, gender, and sexuality creates unique vulnerabilities within and outside Indigenous spaces. The persistence of these encounters throughout daily life reinforces mental health challenges, contributing to an ongoing cycle of distress and avoidance that exacerbates health disparities.

Case Study

Indigenous Australians who identify as LGBTQ+ often face compounded mental health challenges due to the intersection of their cultural and sexual identities. Matthew Shields, an actor, dancer, and registered nurse, recounts his experiences growing up in Walgett, New South Wales. At 16, he endured derogatory slurs based on being Indigenous and for being Queer leading to chronic depression. These narratives highlight the unique pressures faced by Indigenous LGBTQ+ individuals, who often confront racism and homophobia. Such intersecting discrimination exacerbates mental health issues, underscoring the need for culturally sensitive support systems that address both aspects of their identity. Despite these challenges, Indigenous LGBTQ+ individuals demonstrate remarkable resilience, drawing on their cultural heritage and community support to navigate and overcome these adversities.

Source: Buzzfeed (Clarke, 2018)

Systemic Racism in Healthcare Settings

Systemic discrimination in healthcare settings continues to be a substantial barrier for Indigenous Australians. Studies show that healthcare experiences are often shaped by cultural stereotyping and dismissive treatment from healthcare providers, resulting in inadequate care and subsequently reduced service engagement – both individually and on a community and intergenerational level. As an example, Sullivan et al. (Sullivan et al., 2019) document how incarcerated Indigenous women frequently reported being accused of drug-seeking when requesting pain management, leading to their healthcare needs being disregarded. Kelaher et al. (2014) found that a staggering 97% of respondents experienced some form of racism in healthcare settings, leading to diminished trust and higher distress levels. Jamieson et al. (2023) further highlight how discriminatory treatment in healthcare restricts Indigenous individuals' access to adequate care, exacerbating existing health disparities. This systemic stereotyping not only diminishes the quality of care received but also erodes trust in healthcare systems, leading to reluctance to seek care, potentially even in critical health situations (Hole et al., 2015). McCormack, Dickson et al. (2024) highlight how harmful stereotypes and assumptions in sexual health consultations undermine culturally safe care. One participant, a bisexual Aboriginal woman, described how healthcare providers focused solely on her relationships with men, reflecting racist and heteronormative assumptions about Aboriginal sexuality. This intersection of systemic racism, sexism, and homophobia fosters mistrust and deters engagement with healthcare services, particularly for young Aboriginal people navigating sexual health.

Similarly, Temple, Kelaher, and Paradies (2019), using data from the National Aboriginal and Torres Strait Islander Social Survey, found that 31% of older Aboriginal and Torres Strait Islander people report unfair treatment when accessing health services, while a further 17% engage in avoidance behaviours, commonly as a result of prior negative experiences. These avoidance behaviours compound health risks as individuals delay or entirely forego necessary healthcare interventions.

Case Study

In May 2023, the Queensland Health Ombudsman released a report showing systemic failures at Doomadgee Rural Hospital following the death of Adele Sandy, a 37-year-old Indigenous woman with rheumatic heart disease. Adele was repeatedly sent home despite her deteriorating condition, reflecting a broader neglect of Indigenous health needs in many healthcare settings. The Doomadgee community expressed deep outrage, highlighting long-standing issues of poor

healthcare access, inadequate resources, and disregard for cultural safety. Community leaders criticised the hospital's failure to implement recommendations from a 2020 review, calling it an ongoing injustice against their people.

This case illustrates the urgent need for culturally informed healthcare reforms. The voices of community members emphasised the systemic neglect and the critical importance of addressing healthcare disparities to prevent further avoidable deaths.

Source: ABC Four Corners (Milligan, 2023)

Educational Racism and its Developmental Impact

In educational settings, racism towards Indigenous students is also pervasive, manifesting as verbal harassment, stereotyping, and exclusion. This form of racism not only affects Indigenous children's academic engagement but also hinders their social and emotional development. Findings from the Longitudinal Study of Indigenous Children (Twizeyemariya et al., 2017) show that nearly 29% of Indigenous children have experienced discrimination by age 10, negatively impacting their psychological well-being and leading to social withdrawal and reduced self-confidence. Cave et al. (2019) found that racial discrimination within educational settings contributes to significant emotional and social challenges for Indigenous children, impacting self-esteem and school performance. These early experiences of racism can have enduring consequences, contributing to a trajectory of cumulative disadvantage that impacts key social determinants of health including educational attainment, employment opportunities, and access to secure housing and income. These early encounters with racism, in addition to intergenerational trauma, have the potential to create a foundation of distrust and social disengagement that can last throughout adulthood, impeding both educational and professional aspirations as well as impacting on mental, physical and social health and wellbeing (Moore et al., 2015).

Workplace Discrimination and Socioeconomic Implications

Similarly to educational environments, discrimination against Indigenous Australians remains widespread in the workforce, continuing a circle of racism and discrimination. This continuing and compounding racism contributes to lower job satisfaction, insecurity, and psychological distress. Research by Temple, Kelaher, and Paradies (2020) reports how workplace racism frequently results in derogatory remarks and exclusion, with 45% of Indigenous individuals experiencing racial discrimination in the workplace, often directly impacting their mental health. This aligns with Durey et al. (2016), who noted that such discrimination limits job mobility and perpetuates socio-economic disadvantages, perpetuating cycles of socio-economic disadvantage and exacerbating existing health disparities by limiting job mobility and financial security for Indigenous Australians.

Cultural Disconnection and Identity Strain

For Indigenous Australians, experiences of racism often lead to a cultural dissonance, where individuals feel torn. The Mayi Kuwayu Study in a sample of 9,951 Indigenous adults, led by Thurber et al. (2022), found that discrimination was strongly linked to indicators of reduced cultural wellbeing, such as diminished control over life and weakened connection to Indigenous culture. Murrup-Stewart et al. (2021) also found that cultural disconnection due to racism leads to reduced emotional well-being, emphasizing the importance of cultural identity in Indigenous Australians' health. This identity strain amplifies mental health risks, as individuals face challenges reconciling their cultural heritage within a predominantly non-Indigenous society with a history of discrimination and marginalisation of Indigenous cultures (Yencken & Porter, 2001). Cultural disconnection, reinforced by discriminatory experiences, undermines Indigenous Australians' social and emotional wellbeing, which is foundational to all aspects of health (Murrup-Stewart et al., 2021).

Interpersonal Racism in Social Services and its Health Consequences

Interpersonal racism also affects Indigenous Australians in their interactions with social services. Studies show that these encounters can discourage individuals from seeking

assistance, often due to fears of being judged or mistreated based on their cultural background. For example, research by Baba et al. (2014) shows that discriminatory treatment in social service settings negatively impacts Indigenous clients' willingness to seek help and engage with services that are essential for their health and wellbeing. Ferdinand et al. (2015) support this by noting that discrimination and exclusion from essential services perpetuate social isolation and health disparities. This reluctance to engage further isolates Indigenous individuals, exacerbating health risks and perpetuating cycles of disadvantage.

Cumulative Health Impact of Racism

The cumulative impact of discrimination across these various domains significantly contributes to poor health outcomes for Indigenous Australians. Temple et al. (2019) observed that prolonged exposure to racism increases allostatic load, a physiological marker of chronic stress, which is associated with higher risks of cardiovascular disease, diabetes and other stress-related health conditions. These findings suggest that the repeated stress of navigating racism, particularly in essential areas such as healthcare, employment, and education, poses a substantial burden on Indigenous Australians' physical health, further widening health disparities between Indigenous and non-Indigenous populations.

Incorporation of Traditional Healing Practices in Healthcare Settings

In response to the ongoing physical and psychological impacts of racism, some healthcare services have sought to integrate traditional healing approaches that align with Indigenous understandings of health and wellbeing. These practices, which may include spiritual healing, connection to Country, storytelling, ceremony, and bush medicine, reflect a holistic model of care that addresses not just physical symptoms, but also social, emotional, cultural and spiritual dimensions of health.

Several included studies referred to the use or integration of such frameworks. For instance, Farnbach et al. (2021) examined a 12-week residential rehabilitation program for Aboriginal people that was grounded in Aboriginal values and spiritual healing. The program delivered culturally relevant care through group counselling, yarning circles, and work programs, aiming to restore wellbeing through reconnection to culture and community. Similarly, Wright et al. (2021) described the co-design of a mental health evaluation tool that centred First Nations worldviews, demonstrating how Indigenous healing logics can be embedded into service evaluation and design.

Despite these positive examples, traditional healing was rarely the primary focus of research. In many cases, it was referenced only indirectly or through community preferences for culturally safe services. This reflects a broader pattern in which Indigenous knowledge systems—particularly those related to health—are undervalued or excluded within mainstream research and practice. The limited inclusion of traditional healing within the evidence base underscores the need for future research that explicitly investigates the outcomes, mechanisms and roles of these practices in contemporary health systems.

Racism experienced by Indigenous Australians and Other Negatively Racialised People

While Culturally and Linguistically Diverse and Indigenous populations in Australia experience similar types of racism, such as interpersonal and systemic discrimination in workplaces, healthcare and education, there are notable differences in the forms and outcomes of these experiences. Racism itself operates as a critical determinant of health, intersecting with other social determinants such as class, geography, ethnicity, migration status, socioeconomic status, gender, and sexuality to shape health outcomes in multifaceted ways. For Culturally and Linguistically Diverse individuals, the challenges often centre on integration barriers, with stressors like stigma, healthcare accessibility, and the need for social support due to recent migration. In contrast, Indigenous Australians face additional layers of discrimination tied to cultural disconnection and historical marginalisation, which uniquely affect their mental health and socioeconomic opportunities. Both groups experience cumulative health impacts due to repeated discrimination, yet the effects are intensified within Indigenous communities, where the loss of cultural identity and intergenerational trauma further compound these disparities. Recognising the interplay of these intersecting determinants is crucial for addressing the complex and systemic nature of health inequities.

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Appendix 1: Data Extraction Table

(Afsharian et al., 2021)	To investigate the effect of organisational climate on young refugee workers' mental health (psychological distress) through stressful social-relational aspects of work (e.g., harassment, discrimination	Quantitative – Cross sectional	Refugees aged 15-26 (116 with paid work + 519 students without work). Total (n=635) + sample of young workers (n=290)	South Australia. Community	Workplace harassment and abuse. Richman et al. 8-item scale: gender, sexual, racial or ethnic harassment and abuse, being humiliated in front of others or being sworn at, and/or being physically attacked/threatened	Interpersonal	Significant difference between refugee and non-refugee workers in extent of workplace harassment ($p<0.001$), especially more sexual harassment, more unfair treatment due to gender, more negative comments about ethnicity, more humiliation and more physical violence from organisational members.	Significant correlation between workplace harassment and psychological distress (-0.35, $p<0.01$) for refugee and non-refugee samples. Young refugee participants with paid jobs had significantly lower psychological distress than young refugees without jobs. No significant difference between workers in psychosocial safety climate (PSC) risk level.	Not stated.
(Agu et al., 2016)	To explore barriers and enablers to accessing sexual health services, including experiences of stigma and discrimination	Qualitative - key informant interviews + focus groups. Modified grounded theory + thematic analysis.	Sub-Saharan African (SSA), Southeast Asian (SEA), and East Asian (EA) migrants, aged 18-50 who had lived in WA for 1+ year (n=45). 28 female; 24 had university degree/s	Perth metro area.	Stigma and discrimination against migrants: "How do opportunities differ between migrants and non-migrants in terms of accessing health services?". Stigma and discrimination re sexual health: "Often STIs are linked with shame. Why do you think this is the case?"	Systemic discrimination in health services.	Some SSA participants had negative experiences in health seeking, especially non-Medicare holders. SEA/EA participants had no complaints and most experienced equal treatment. Participants reported systemic discrimination in employment (all groups), education and accommodation (SSA only). Discrimination in social settings – preconceived ideas about STIs and PLHIV. SSA participants valued greater knowledge of STI in Australia, but noted stigma-related visa refusal for PLHIV.	Some delays in service delivery (eg testing). Concerns re confidentiality and repercussions of positive HIV test – but influenced by experiences in country of origin where privacy not respected. No confidentiality breaches reported in Australia, but fear influences engagement. Lack of knowledge of sexual health services, esp for SSA participants, and financial constraints affected access. Perceived attitudes of health care providers towards migrants in targeting them for STI screening were cited as discriminatory and a barrier to help-seeking. They felt that targeted screening engendered screening without consent.	Research team: 2 academics, 1 public health research student, and 1 NFP organization manager working with migrant communities. All had interest in topic and in sexual health. Lived experience not stated.
(Ali et al., 2021)	To examine the effects of experiences of interpersonal racism on oral health-related quality of life (OHRQoL) among Indigenous South Australians	Quantitative – cross sectional	Indigenous adults (n=885). 67% female; 78% health care card (HCC); 32% university educated; 33.4% rated oral health as fair or poor.	South Australia. Community sample	Measure of Indigenous Racism Experiences (MIRE) instrument, categorised in either 2 (no racism vs any racism in ≥1 setting) or 3 categories: no racism, low (1-3 settings), high (4-9 settings) in last 12 months	Interpersonal	52.1% reported experiencing any interpersonal racism in the previous 12 months – 31.6% experienced low racism and 20.5% experienced high racism. 17.4% (95% CI: 14.6-19.7) experienced racism in health care settings	Those who experienced any racism were significantly more likely to report poor OHRQoL (OR: 1.43; 95% CI: 1.08–1.92), after adjusting for age, education and other relevant factors. The discrepancy was greater among females – OR 1.74 (95% CI: 1.07-2.81) – for poor OHRQoL among those experiencing racism.	Not stated.
(Au et al., 2021)	To explore the healthcare experiences of refugees in North Queensland.	Qualitative – narrative inquiry method-ology	Refugees ≥18 years old who have used health services 4+ times a year (n=14)	Regional centre - Townsville	Not defined.	Interpersonal and systemic – resource issues, esp lack of interpreters	Discrimination was both perceived and experienced in healthcare system, including bias against those needing interpreter.	Long waiting time although arrived on time; delays in care resulting in clinically adverse events; lack of interpreters; workforce issues; fear of privacy breaches leading to non-disclosure of relevant information; gender boundaries (eg male interpreter); community fear of doctors (medication, child removal); use of non-legal interpreters. Most were grateful to healthcare staff. Regional area had more accessible services and info; but some found services inaccessible – lack of interpreters.	Not stated.

(Baba et al., 2014)	To explore lay perspectives of Aboriginal and Torres Strait Islanders accessing community and government controlled AMS with the intention of identifying self-perceived health determinants to inform the post-2015 international development goals.	Qualitative – interviews + focus groups	Clients of government controlled Aboriginal Medical Service (AMS) (n=10) and an Aboriginal community controlled health service (ACCHS) (n=11)	Brisbane, Qld - AMS and ACCHS.	Not specifically defined.	Systemic and interpersonal	Not measured	Participants identified three major ways that discrimination continues to affect Indigenous health: negative impact on health care seeking behaviour; effect on how Indigenous clients gain essential knowledge for their health and how it is passed on; and directly effect on mental health of Australia's first people. Failure of mainstream health services to acknowledge Indigenous concepts of health – discomfort and miscommunication. Lack of holistic and culturally appropriate health services. Limited referral to appropriate support and prevention programs for NCD. Fear of medical services due to negative past health experiences – leads to avoidance, delay and worsening health. Discrimination and perceived discrimination by staff and other clients. History of discrimination and colonisation has damaged passage of essential life skills eg good nutrition. Widespread support for AMS and ACCHS healthcare services	Not stated
(Bastos et al., 2018)	To investigate how perceptions of racial discrimination predict barriers to healthcare access and to explore whether these effects are compounded by gender, class, and sexuality-based discrimination. To understand how multiple forms of discrimination intersect to shape barriers to healthcare.	Quantitative – cross sectional (using 2014 Australian General Social Survey data)	Individuals ≥15 years old living in Australia (n = 12,368)	National survey	Racism was defined as interpersonal racial discrimination and was measured by asking participants if they had experienced discrimination in the past 12 months due to their skin colour, nationality, race, ethnic group, or language.	Interpersonal, systemic	18.7% of the total sample had experienced some form of discrimination in the past 12 months, with racial discrimination being reported by 34.2% (95%CI = 30.7 – 37.8) of those experiencing any discrimination. 66.3% (95%CI = 61.5 – 71.2) of foreign-born participants and those who have difficulties speaking English have reported racial discrimination over the past 12 months.	Racial discrimination was a significant predictor of healthcare barriers. Participants who experienced racial discrimination were 1.89 times more likely to report difficulties in accessing healthcare vs those who did not experience such discrimination, with a regression coefficient of = 0.634 ($p<0.01$). Participants who reported racial discrimination were significantly more likely to face barriers when trying to access mental health services, with a regression coefficient of = 1.37 ($p=0.002$).	Not stated.
(Ben et al., 2014)	To examine the relationship between self-reported racism and the experience of toothache among pregnant Aboriginal Australians, with an emphasis on psychosocial factors like stress, sense of control, and social support as potential mediators.	Quantitative – cross sectional	Pregnant Aboriginal women (n = 365)	South Australia	Racism was self-reported by participants in response to questions about experiences of unfair treatment due to their Aboriginal identity. Racism was measured in terms of interpersonal racism experienced in various settings, including healthcare.	Interpersonal racism.	Nearly half of the participants (48.9%; n = 176) reported experiencing racism in the past year, with 29.7% (n = 107) indicating experiences of racism in 1-3 settings, and 19.2% (n = 69) reporting racism in 4-9 settings. Over half (51.1%; n = 184) reported no instances of racism in the past year. Among those who reported experiencing racism (n = 176), the most common setting was public spaces - 31.9% of all participants (n = 116), followed by law enforcement settings (22.8%; n = 83) and domestic settings (20.6%; n = 75).	35.6% of participants reported experiencing toothache in the past 12 months. Self-reported racism was significantly associated with toothache (OR: 1.99, 95% CI: 1.07–3.72). Sense of control was found to partially mediate the relationship, with 21.2% of the effect explained by a lack of perceived control.	Not stated

(Bernardes et al., 2022)	To investigate the communi-cation experiences and healthcare access barriers faced by Aboriginal and Torres Strait Islander people managing pain, with a focus on understanding how communi-cation impacts trust and care.	Qualitative – interviews + focus groups	Aboriginal and Torres Strait Islander patients (n = 13) and Aboriginal and Torres Strait Islander Hospital Liaison Officers	QLD - three persistent pain clinics and two hospitals	Racism was identified through patients' reports of being treated differently or unfairly by healthcare providers due to their Aboriginal or Torres Strait Islander identity.	Systemic and interpersonal discrimination within healthcare settings.	Participants frequently reported feeling stigmatised for identifying as Aboriginal or Torres Strait Islander, with some reluctant to disclose their background due to fear of unequal treatment. Miscommunication and lack of cultural competence were common issues.	The study noted that poor communication and perceived discrimination led to delays in accessing pain management services, reduced trust in healthcare providers, and poorer pain management outcomes.	Five authors are of Aboriginal or Torres Strait Islander background; other team members of culturally and linguistically diverse background.
(Bolsewicz et al., 2022)	To explore the barriers to childhood immunisation for First Nations and non-First Nations families in Kempsey, NSW, and to identify strategies to improve vaccination rates.	Qualitative – interviews + focus groups	First Nations and non-First Nations mothers and grandmothers (n = 38), and health service providers (n = 18)	Kempsey, NSW - community health services	Racism discussed in relation to entrenched community attitudes and access to health services for First Nations families, measured through participants' descriptions of unequal treatment and structural barriers.	Systemic racism, particularly in access to healthcare services and logistical barriers linked to socio-economic disadvantage	First Nations mothers reported facing systemic barriers to accessing immunisation services, including limited access to transport, lack of culturally safe services, and entrenched racism in the community.	Poor immunisation coverage among children of First Nations families, attributed in part to structural barriers related to racism and cultural safety issues within healthcare services.	Aboriginal Immunisation Health Workers were part of the research team and led the engagement with community and facilitated focus groups. They were also involved in data analysis and the selection of quotes.
(Brener et al., 2015)	To explore whether attachment to an Aboriginal community promotes healthier lifestyle changes after receiving a hepatitis C (HCV) diagnosis.	Quantitative – cross sectional	Aboriginal Australians living with HCV (n = 203)	NSW, recruited from Aboriginal Community Controlled Health Services	Racism was assessed using a modified version of the Group-Based Medical Mistrust Scale - participants rate perceptions of racial discrimination in healthcare on a 5-point scale to measure the extent to which participants felt Aboriginal people were treated differently by healthcare workers.	Interpersonal and systemic racism, particularly related to stigma from healthcare providers and the broader community.	Participants reported moderate levels of perceived racial discrimination in healthcare with a mean of 3.23 (D = 0.85) on a 5-point scale.	Strong community attachment was associated with improved quality of life, reduced stigma, and more positive lifestyle changes, such as reduced alcohol consumption and increased healthcare engagement.	Not stated.
(Brown et al., 2023)	To explore the positive and negative care experiences of Aboriginal and Torres Strait Islander Australians diagnosed with cirrhosis with a focus on support needed.	Qualitative – yarning methods	Indigenous patients with cirrhosis (n = 13) and support persons (n = 3)	Liver clinics in 5 hospitals in Brisbane and Logan, QLD	"Health-related stigma and discrimination that can then lead to inequitable access to healthcare"	Interpersonal; systemic	A few participants experienced prejudice and discrimination from HCPs when they received a diagnosis of cirrhosis, particularly participants with cirrhosis due to alcohol misuse or chronic HCV. Some HCPs did not understand different types of cirrhosis – not all due to alcohol. Some HCPs reported as very supportive, informative and non-discriminatory – esp liver specialist nurses. Other participants experienced a lack of compassion - doctors seen as insensitive when raising issues such as advanced care directives or the risk of death.	Barriers related to poor health literacy, stigma and lack of practical and emotional support, and issues with communication and patient consultation, may lead to inequitable access to cirrhosis care and treatment for Indigenous Australians. Long delays in the system led to late diagnosis – multiple doctors and problems organising appointments. Some experienced lack of continuity of care, overwhelming number of clinic appointments and the lack of flexibility with regards to changing appointments. HCPs made judgements or assumed that cirrhosis was equivalent to alcohol misuse, which potentially demonstrates a lack of understanding of cirrhosis. Limited health literacy among some participants – could be improved by better information and communication from health services.	Two authors are of Aboriginal backgrounds; 5 remaining authors are non-Indigenous, including clinicians and non-clinicians. Most interviews were conducted with one interviewer, an Indigenous woman, descendant of the Noonucal group of the Quandamooka people of Minjerribah— North Stradbroke Island. Three interviews conducted by 1 Indigenous and 1 non-Indigenous researcher. The study included Indigenous as well as non-Indigenous perspectives and clinical and non-clinical perspectives, and stressed reflexivity.

(Brown et al., 2019)	To investigate the relationship between perceived discrimination in perinatal care and birth outcomes of women giving birth to an Aboriginal baby in South Australia using methods designed to respect Aboriginal culture and communities.	Quantitative – structured survey, F2F interview or self-completed	344 women (mean age 25, range 15–43 years) living in urban, regional and remote areas of South Australia who had given birth to an Aboriginal infant. Representative of Aboriginal women giving birth in SA.	South Australia	4 questions based on the Measure of Indigenous Racism Experience (MIRE). Adapted Qs: 1) Experiences of hospital or health service staff talking down to you; (2) Being treated with less respect than other people by staff; (3) Perceiving that you got poorer care from staff than other people; (4) Being insulted, judged or ignored by staff	Interpersonal. Perceived discrimination in perinatal care – antenatal, intrapartum and postnatal care over 12 months. Did not record specific actions or contexts (e.g. public hospital, GP clinic, community health centre) or HCPs (e.g. obstetrician, midwife, ward clerk) involved.	51% perceived that they had experienced discrimination or unfair treatment by hospitals or health services providing care during pregnancy and soon after childbirth. Much higher than 25% rate in general population sample with same Qs. 5.9% often; 19.6% sometimes; 13.6% rarely 6.2% often; 14.8% sometimes; 13.6% rarely. 6.8% often; 10.7% sometimes; 11.6% rarely 6.6% often; 12.5% sometimes; 10.1% rarely. Higher rates of discrimination for those who used cannabis; had 3+ children; rated antenatal care less than good.	Aboriginal women who perceived that they had experienced discrimination in perinatal care were more likely to have a baby with a low birthweight (aOR 1.9, 95% CI 1.0–3.8) or small for gestational age (SGA) (aOR 1.9, 95% CI 1.0–3.5), adjusting for parity, smoking and cannabis use. No relationship between discrimination and premature birth (<37/40). Rates of low birthweight and SGA were approx. 2x those in general population. Women experiencing three or more stressful events or social health issues were more likely to perceive that care was discriminatory or unfair. Evidence of the 'inverse care law': women most at risk of poor infant health outcomes were the least likely to perceive that they received care well matched to their needs.	Conducted in partnership with Aboriginal Health Council of South Australia, extensive community consultation preceding design of the study, and guidance provided by the Aboriginal Advisory Group. Community consultation informed decision to include a measure of discrimination/unfair treatment in perinatal care, and to adapt/test Qs. A team of 12 Aboriginal research interviewers, all of whom had strong connections with Aboriginal communities in South Australia, recruited women via public hospitals, community-based agencies, community events and their own community networks.
(Burford-Rice et al., 2020)	To explore the impact of sustained negative media reporting on the lives of a sample of women with refugee backgrounds from South Sudan living in South Australia.	Qualitative, semi-structured, face-to-face interviews	9 South Sudanese people ≥18 years old, who had been in Australia 3+ months (average=13 yrs); aged 25-70 years. 7 women; 2 men; all Christian. None requested or required interpreter.	Adelaide, South Australia. Interviews at time of widespread reports of violence by 'gangs' in media and politics.	Negative depiction of the South Sudanese community as problematic.	Systemic (media) and inter-personal	"Significant portions of the interview were devoted to discussing experiences of racism and the impact of negative media reporting of Sudanese refugee communities in Australia" (p100) Overwhelming negative stereotyping of South Sudanese Australians in media and public discourse. Community generalisations based on portrayal of a small minority of young people. No alternative framing – unfair. Portrayal leads to direct experiences of racism "it's normal... just life"	This paper arose from study of help-seeking for mental health services. They "consistently highlighted the impacts of these negative depictions of their community on their psychological health and well-being during interviews." Also recounting distress among their children who experience racist behaviour.	Uses principles from community based participatory research – equal partnership, shared learning; attention to power dynamics between parties; and active involvement of community stakeholders. First author spent considerable time developing relationships within the South Sudanese community in Adelaide. First author approached by a male community leader expressing concern about general mental health issues and recent suicides in his community. He advocated for research to be conducted with an aim to improve access to services and encourage dialogue about mental health concerns. Snowball sampling

(Butten et al., 2021)	To gather Australian Aboriginal and Torres Strait Islander parent/ carer perspectives of HR-QoL in children with chronic illness to inform the development of a culturally appropriate tool.	Qualitative phenomon-ological approach, using yarning	26 parents/ carers of Aboriginal and/or Torres Strait Islander descent and were, or had been, the carer of an Indigenous child aged <18 with a chronic illness (= any condition which affected the child's daily life and required them to attend the doctor and/or hospital regularly)	Capital cities and regional centres in Queensland and Northern Territory	Not defined.	Inter-personal; systemic	Although not raised with each concept, there were undertones of perceived racism and discrimination in many topics discussed. Parents and carers explained what they valued in relation to HR-QoL, and this was often the absence of prejudicial behaviour from health services, be it overt or sub-conscious. Experiences of judgement from health system, including : HCPs making negative assumptions about children and their families; not believing or trusting parents/ carers; unwelcoming environments where parents/ carers felt judged and unable ask questions or engage with HCPs confidently. Experiences of being treated differently because of their Indigenous identity - negative stereotyping, particularly re their capacity to care for their child.	Physical, social, emotional and cultural health were described as important components of HRQoL. When communication was perceived as being insufficient, too complex or disrespectful, families were left feeling disenfranchised from the health system and its stakeholders. Health communication continues to be problematic and impact on concepts related to Indigenous Australian HRQoL. Judgement from the health system had ramifications on child HR-QoL – lack of trust. A common theme raised by participants was that they had to invoke negative stereotypes, such as 'the angry black woman' in order to get what they needed from the health system, be that attention, information, or physical care for their child. The additional stress and energy from having to advocate at such a high level had detrimental effects on families. Cultural health was also raised as an attribute of overall health and wellbeing.	Historically, research with Indigenous Australians has been paternalistic and failed to privilege Indigenous ways of knowing. Uses phenomenology to incorporate Indigenous research methods eg yarning. Of the 8 authors, MT, an Aboriginal woman, is one of the study's chief investigators and co-researcher, KB's PhD supervisor, and provided cultural oversight for the entire study. KB is a non-Indigenous Canadian/Australian woman and is first author.
(Cave, Cooper, et al., 2019) **"Caregiver-perceived racial discrimination is associated ..."**	To explore the relationship between caregiver-perceived racism exposure and a range of mental health and related behavioural and physiological outcomes in childhood.	Quantitative	1759 Aboriginal children aged 4–12 years from waves 2–8 (2009–2015) of the Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC) dataset - national sample of Aboriginal children across 2 age cohorts, approx. 5-10% of total population of Aboriginal children.	11 geographic sites across Australia.	Exposure to caregiver-perceived racism between 4 and 11 years. Question on whether the study child had been bullied by children and/or treated unfairly at preschool or school by adults because they were Aboriginal (always or sometimes for this reason).	Inter-personal	20.4% children in LSIC between 4–11 years experienced at least one exposure to caregiver-perceived racial discrimination at school from either adults or peers – more common in most disadvantaged areas, those whose primary carer experienced homelessness in past 5y.	Perceived exposure to racism at ages 4–11 was associated with twice the risk of negative mental health (95% CI: 1.3–3.0), sleep difficulties (95% CI: 1.4–3.0), and behaviour issues at school (95% CI: 1.2–2.9), 1.7 times the risk of obesity (95% CI: 1.1–2.5), and nearly 7 times the risk of trying cigarettes (95% CI: 1.1–45.0). Increased risks were also found for being underweight and trying alcohol though estimates did not reach statistical significance. There was no evidence that racism was associated with poorer general health.	Acknowledgements state: "We wish to thank members of the Social Determinants of Aboriginal Health Community Advisory Group for their valuable assistance in developing and guiding this research" NB LSIC had strong community involvement.

(Cave et al., 2020) **"Racial discrimination and allostatic load..."**	To determine the effect of exposure to racial discrimination on allostatic load in profiles of Aboriginal adults defined by stress-related psychosocial, environmental, and health factors.	Quantitative	2056 Australian Aboriginal adults from Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) 2012–13 from Australian Bureau of Statistics (ABS). 53.6% female.	National representative sample of Aboriginal Australians.	Respondents were asked whether they had felt they had been treated badly in last 12 months because they were Aboriginal or Torres Strait Islander (yes/no). No measure of frequency, duration or location of exposure to racial discrimination. Single-item measure, not validated.	Inter-personal	14.6% (12.4-16.8) experienced racial discrimination in last 12 months.	Physiological health measured by allostatic load index derived from 10 biomarkers to indicate effects of stress exposure. Mean 2.4 biomarkers per individual = high-risk category. A statistically significant increase in mean allostatic load was observed in participants who reported racial discrimination, after adjustment for age and gender (B = 0.38, p = .02). Mean allostatic load varied significantly between latent classes both for those with (Z = 67.5, p = <.001) and those without exposure to racial discrimination (Z = 235.5, p = <.001). Mean estimated allostatic load was significantly higher for those in 'multiple challenges' class with exposure to racial discrimination vs those unexposed (t = 1.74, p = .04),	"Led by the Centre of Excellence for Aboriginal and Torres Strait Islander Statistics, the ABS is guided by cultural protocols and procedures for engagement with Aboriginal peoples and communities developed in alignment with Indigenous data sovereignty principals [49, 50]. The current study received input and guidance on the study design and interpretation of findings from the Telethon Kids Institute Social Determinants of Aboriginal Health Community Advisory Group, an advisory group comprised of Aboriginal community members from the Perth region (Western Australia) established to ensure this research was directed and approved by the local Aboriginal community."
(Cave, Shepherd, et al., 2019) **"Racial discrimination and the health and wellbeing of Aboriginal and Torres Strait Islander children..."**	To examine the impact of timing of exposure to racial discrimination	Quantitative	1759 Aboriginal children aged 0.5–12 years from waves 2–8 (2009–2015) of the Footprints in Time: LSIC dataset - national sample of Aboriginal children across 2 age cohorts, approx. 5-10% of total population of Aboriginal children.	National study – 11 sites.	Exposure to caregiver-perceived racism. Question on whether the study child had been bullied by children and/or treated unfairly at preschool or school by adults because they were Aboriginal (always or sometimes for this reason). First exposure dichotomised to either 4-5 years or 7 years	Inter-personal	6.9% of sample first exposed to racism at 4-5 years. 8.3% first exposed at 7y.	By 7–12 years, 17% of study children reported to have negative MH or behavioural issues at school, 18% of children had obesity, 4% were underweight and 3% of children were identified as having fair or poor general health. At 6–11 years, 21% of children were reported to have experienced difficulty sleeping. In fully adjusted model, larger effect (OR: 2.8; 95% CI: 1.4–5.4) for negative mental health with first exposure at 4–5 years compared to 7 years (OR: 2.1; 95% CI: 1.2–3.6), referenced to children with no exposure. No difference in effect sizes in both exposure groups for the significantly increased risk of sleep difficulties (OR 2.2 vs OR 2.1), while a stronger adverse effect on behavioural issues was found at 7 years (OR: 2.2; 95% CI: 1.3–4.0) relative to 4–5 years (OR: 1.7; 95% CI: 0.8–3.7), compared to children with no exposure to racism. No significant associations were found with general health, obesity or being underweight	"We wish to thank members of the Social Determinants of Aboriginal Health Community Advisory Group for their valuable assistance in developing and guiding this research" LSIC has strong community involvement.

(Chalmers et al., 2022)	To qualitatively examine Indigenous women's body image, focusing on the connections between racism, colourism, and cultural identity	Qualitative with group yarning and 1:1 interviews.	16 participants who self-identified as female, identified as an Indigenous person, and ≥18 years old.	Naarm based research, but "our participants came from a wide range of Indigenous groups associated with a specific part of Country and/or place (mob)"	Racism and colourism are two related but distinct forms of discrimination. Racism enacts beliefs that systemically subjugate people/s based on their race and/or ethnicity and culture. Colourism refers to simultaneous privileging of light-skinned individuals and discrimination against darker-skinned individual, affirming Western racial hierarchies.	Racism occurs on 3 inter-connected levels: internalized (feeling negative about own racial group); interpersonal racism, which can be either intra-racial or inter-racial; systemic, institutional racism implemented at a policy level.	Interracial, systemic, intra-racial, and internalised racism were all noted in participants' conversations as experiences that weakened their cultural identity 3 main themes: (i) Dominant beauty ideals in Australia exclude Indigenous women (ii) Variations in Indigenous women's identities and appearances (eg skin colour) influences the types of discrimination received and impacts sense of belonging. White passing people "aren't always valid in own community as being black", further confounded by gender and sexual identity. (iii) A change journey occurs over time towards body acceptance, informed by changing understandings of body image and cultural identity. Having a strong sense of cultural identity is protective against discrimination. Some noted the stigma of looking Indigenous was prevalent and felt excluded from spaces based on their skin colour and their bodies including public spaces. The extent of this discrimination was contingent on how dark someone's skin was.	Participants described racism and colourism as negatively impacting their body image. Developing a strong cultural identity mitigated these impacts by facilitating both a sense of belonging and body acceptance – highlighting a potential protective factor. Sense of cultural identity weakened by experiences including being invalidated, questioned, or rejected by the Nation [political, economic, and institutional structures of colonial Australia] and other Indigenous peoples, and feeling disconnected from culture. Some participants noted they felt invalidated by their own families, especially if these family members were white. Varying experiences of intra-racial racism, discussed in terms of 'lateral violence'. Intra-racial racism among Indigenous peoples depends on part of Country – people moving to other regions or cities more likely to experience invalidation, questioning and possible rejection from Indigenous peoples of that community, especially if participant's skin colour was fairer. Participants valued mob's opinions about cultural identity above that of the Nation and non-Indigenous peoples, where invalidation from mob was likely to negatively affect their cultural identity. (479) The more participants spoke about their body image being contingent on others' opinions, the more likely they were to compare their body to white Australian beauty ideals and feel unhappy with their body image. (p480)	The researcher in this study, AC, is a proud Aboriginal woman in her early 20 s who has grown up on Ngunnawal Country in Canberra, and has also lived on Wurundjeri Country in Naarm (Melbourne) for six years. The researcher identifies with Indigenous women, but also recognises that her experiences as a fair-skinned Indigenous woman living in urban areas and undergoing tertiary education are not synonymous with the experiences of all Indigenous women. These characteristics may have informed data collection and analysis; eg, being a young, fair-skinned Indigenous woman may have made it easier for the researcher to relate to other young, fair-skinned Indigenous women than to older Indigenous women with darker skin.

(Collins et al., 2022)	To consult an ACCHO's community about the barriers to and enablers of oral health and understand their lived experiences with dental services.	Qualitative – using Aboriginal knowledge framework and collaborative approach – 4 semi-structured individual interviews and 5 yarning circles	21 community members, ≥18 years old eligible for health care at the ACCHO + staff at the ACCHO. Aged 19-87, 11 female.	Rural Victoria – area with high levels of oral disease	Not defined	Inter-personal	Participants' past experiences of dental care involved pain and shame. People felt judged and felt like they were not good enough when dental clinicians 'lectured' patients around dental care. The impacts of colonisation, racism and generational trauma for Aboriginal people also contribute to entrenched feelings of inferiority multiplying shame, leading to reluctance to access services. Findings indicate that embarrassment about poor oral health is linked to feeling shame and fear of being judged and is commonly experienced within this community, contributing to avoiding dental appointments	Some participants said that due to the shame or embarrassment they feel about the condition of their teeth, they are likely to avoid dental visits because they have received or expect judgement from the clinicians. It was overwhelmingly common for participants to access the dental service only when they were experiencing pain rather than for regular care or preventative services. This was largely due to traumatic dental experiences in their past or from hearing horror stories about dental treatment from other community members. Participants want clinicians to stop lecturing and tailor oral health information to the individual. There is a belief that dental practitioners enjoy inflicting pain making the clinical environment unwelcoming, which is reinforced by the language and body language practitioners use. Practitioners lecturing patients don't understand reasons for health behaviours (eg using drugs, soft drink) – they should allow time to get to know patients and provide relevant info. To properly engage with community members, participants felt that dental practitioners and dental staff should connect with community groups outside of the clinics. HCPs need to understand that the legacy of colonisation, assimilation policies, racism and victim-blaming approaches to health has created inequality in oral health status for Aboriginal people	Project was initiated by a rural Victorian ACCHO (Aboriginal Community Controlled Health Organisation) to consult their community. Study used an Aboriginal knowledge framework and collaborative approach involving an Aboriginal lead researcher and Elder as Community Mentor, to bring community views to the project, advise on culturally safe approaches, contribute to engagement and champion the project in the community, to help with recruitment and contribute to cultural continuity in the thematic analysis and findings. Questions were developed collaboratively by the research team, which included the ACCHO Lead Researcher and Community Mentor. The non-Indigenous Australian researcher conducted a month of community engagement to help the community feel at ease around the researcher before the yarning groups. ACCHO LR was not involved in data collection to protect confidentiality and to mitigate dependent relationships. and semi-structured interviews were conducted.
(Collins et al., 2021)	To develop and pilot a novel method for exploring and reporting on implicit racial bias by community pharmacists in their practice setting	Qualitative using covert simulated patients and discourse analysis.	4 female actors (Caucasian, East Asian, Middle Eastern and Indian appearance) + pharmacy staff in 8 community pharmacies = 32 visits.	Community pharmacies	Discussions between actor and pharmacist categorized into caring, neutral, abrupt, based on post-visit interview with actor and transcription of audio recording – only 3 cases where the rating differed between methods.	Inter-personal implicit racial bias	Caucasian actor appeared to have more interactions considered to have a 'caring' discursive frame, whereas the South Asian actor appeared to be involved in more interactions with an 'abrupt' frame. The mixed-method design identified that fewer questions were associated with an 'abrupt' frame.	No variation between visits in length of consultation, number of products sold, and number of questions asked	Not stated
(Cooper et al., 2019)	To explore the prevalence, course, and predictors of mental illness in population of permanently resettled refugees, through first 3 years of resettlement.	Quantitative study using longitudinal dataset - Building a New Life in Australia (BNLA) study.	2,399 humanitarian migrants ≥15 years old recently resettled in Australia, from nationally representative cohort. High levels of PTSD and high risk of severe mental illness (HR-SMI)	11 confidential locations around Australia	'Discrimination' – not defined	Not stated	Not stated	At baseline, 30.3% (95% CI, 28.5–32.2) of participants screened positive for PTSD, and 15.4% (95% CI, 14.0–16.9) of participants screened positive for HR-SMI. High prevalence of mental illness persisted over first 3 years of resettlement. HR-SMI positively associated with 'experiencing discrimination' (among other variables) (OR=2.10, 95% CI, 1.06-4.14). PTSD not significantly associated with discrimination	Not stated

(Correa-Velez et al., 2015)	To explore whether the factors that predict wellbeing in the short term persist over time as these adolescents transition to young adults.	Quantitative – longitudinal study over first 8 years in Australia.	120 young people during first year in Australia (55 female). N reduced in each wave to 51 at wave 5 (no statistically signif difference in those lost to follow up)	Recruitment through English Language Schools – location not stated.	Perceived discrimination. 1 item from Experiences of Discrimination Scale. 'Ever experienced discrimination because of your ethnicity, religion or colour?' Y/N 'The Australian community cares about me' (1 =not at all to 4=very much)	Not stated	Not stated	Refugee migrant youth who had experienced discrimination scored significantly lower in both subjective health status (0.32 lower on average; 95% CI [0.59, 0.05]; p = 0.022) and levels of happiness (0.37 lower on average; 95% CI [0.57, 0.17]; p < 0.001). This study provides strong evidence in support of policies that discourage discrimination and promote social inclusion and cultural diversity and which underpin the wellbeing of resettled refugee youth.	Not stated
(Daly et al., 2018)	To explore work-related psychosocial stressors among people of Chinese, Vietnamese and Arabic-speaking backgrounds currently working in Australia.	Quantitative study using CATI telephone survey.	585 Vietnamese, Chinese and Arabic-speaking workers (195 each). ≥18 years old. 10.7% born in Australia.	Suburbs with high concentration of residents of Arabic, Chinese, or Vietnamese background in Melbourne, Sydney, and Perth	Ethnic discrimination – 2 items from General Ethnic Discrimination Survey 2015 – unfair treatment by employers and by co-workers. Measured recent and discrimination over lifetime. Bullying in the workplace in last 6/12 – Y/N.	Inter-personal	Prevalence of ethnic discrimination or being bullied not stated. BUT "These results are consistent with previous research in Australia that found that between 40% and 52% of refugee workers reported experiencing work-related discrimination". Ethnic discrimination: Not assoc with ethnicity. signif higher for workers 45+ often combined with poor job security and low control assoc with higher education level. Being bullied signif higher for workers 45+ more common for Chinese workers less likely for those speaking English at home.	A total of 432 (82.9% [79.4, 85.9]) participants reported experiencing at least one of the workplace psychosocial stressors, including being bullied and ethnic discrimination (also reported complexity, control, security and unfair pay) Compared with Vietnamese workers interviewed in a language other than English, Chinese and Arabic speaking workers had lower psychosocial job quality. Compared with workers in managerial occupations (the reference group), all other occupations were associated with lower psychosocial job quality. Arabic-speaking workers had almost three times the risk of experiencing more workplace psychosocial stressors compared with their Vietnamese and Chinese counterparts	Not stated.
(Doery et al., 2023)	(1) to estimate prevalence of direct discrimination, vicarious racial discrimination, heightened vigilance, worries about experiencing racial discrimination, COVID-19-related stressors and mood state; (2) to examine associations between self-reported ethnicity and experiences of discrimination and COVID-19-related stressors; and (3) to examine associations between discrimination, COVID-19-related stressors and mood state.	Quantitative – community-based online survey	363 young people aged 16–24 years. 45.3% self-identified as being from a multicultural background and 3.7% as Aboriginal and/or Torres Strait Islander. 65.7% women	Victoria – during June 2020 COVID lockdown (increased reports of racism).	Direct discrimination: Adolescent Discrimination Distress Index – 11 Y/N items. Vicarious racial discrimination: Online Victimization Scale for Adolescents - 4 Y/N items. Heightened vigilance: adaptn of Chicago Community Adult Health Study – 4 Y/N items. Worries about experiencing racial discrimination: new measure with 4 Y/N items. Responses to racial discrimination: MIRE – 1 item "what did you do?"	Interpersonal	Of total sample, 73.7% reported direct discrimination, 88.9% vicarious racial discrimination, 84.3% heightened vigilance, and 62.8% worries about experiencing racial discrimination. Participants who self-identified as Aboriginal and/or Torres Strait Islander: 74.8% reported direct discrimination, 100% vicarious racial discrimination, 87.1% heightened vigilance, and 100% worries about experiencing racial discrimination. For participants from multicultural background: 85.1% reported direct discrimination, 91.6% vicarious racial discrimination, 91.9% heightened vigilance, and 86.8% worries about experiencing racial discrimination.	Half (51.3%) participants experienced 1-2 COVID-19-related stressors. 53.1% of participants reported moderate-to-high levels of distress or negative mood state. 56.4% of Anglo-European participants, 48.6% of multicultural participants and 63.3% of Aboriginal and/or Torres Strait Islander participants reported moderate-to-high distress. Direct and vicarious discrimination increased for participants self-identifying as Indigenous (0.7) or multicultural (0.4). Negative mood state associated with direct discrimination, vicarious racial discrimination, heightened vigilance, worries about experiencing racial discrimination (and COVID related stressors).	Data used in this study was collected by the Centre for Multicultural Youth (CMY), a not-for-profit organisation based in Victoria that works with and for young people from migrant and refugee backgrounds. CMY places young people at the heart of all of their work, working with communities, service delivery organisations, decision-makers at local, state and national levels, and researchers to enact change and enable young people to reach their full potential.

(Durey et al., 2016)	To investigate Aboriginal Health Workers' (AHWs) perceptions of barriers and enablers to oral health for Aboriginal people.	Qualitative – semi-structured interviews and focus groups	35 health workers (28 females and 7 males) – included for personal and professional insights	13 sites in Perth	Not defined – includes judgement, patronization, shame, fear of removal of children for neglecting their teeth, legacy of colonization and child removal.	Inter-personal and systemic	Not measured	Structural barriers to oral health improvement: cost of services on limited budgets, insufficient education about oral health and preventing disease, access to dental services; public dental services not meeting demand, limited interprofessional practice (eg medical/dental; dental/AHW); oral health resources inappropriate; and blame and discrimination from some health providers. Health providers seemed to have little understanding of the historic and social context of Indigenous people's lives Social barriers: cost of healthy diets on limited budget (especially if sharing or moving around); shared households and limited space; treating pain with analgesics; attending services for pain not prevention; fear of extraction;	Following an extensive consultation process with key Aboriginal and non-Aboriginal stakeholders during 2013–2014, researchers followed up on contacts in various health services in Perth to invite AHWs to participate. Interviews conducted either by an Aboriginal or non-Aboriginal researcher or, where possible, by both.
(Durey et al., 2017)	To investigate the perspectives and experiences of Aboriginal carers, predominantly mothers, in terms of factors affecting their oral health and that of their children. Our project aimed to privilege the voices of Aboriginal participants.	Qualitative – focus groups	52 Aboriginal parents of young children, mainly mothers (2 fathers) and other family carers.	10 sites in Perth	Not defined.		Discrimination from health providers not measured, but frequently cited. Participants felt discriminated against because of their Aboriginality, socioeconomic status, the state of their oral health, and bringing children to services that were not child friendly. Reasons included staff at dental services making negative assumptions about their Aboriginality. Shame and humiliation from inability to pay outstanding bills. Shame about state of oral health – affects self-esteem.	Structural factors, including policy and organizational practices that adversely preclude participants from making optimal oral health choices: limited education about prevention, prohibitive cost of services, intensive marketing of sugary products, and discrimination from health providers resulting in reluctance to attend services. Public dental services require attendance at 8am – not possible for those responsible for young children. Discrimination was cited as a reason to avoid dental services in most discussion groups. Shame about state of oral health – affects self-esteem and exacerbated if participants were treated disrespectfully, patronized, or judged negatively by staff, which often led to avoiding dental visits altogether. Disliked being lectured.	Extensive consultation with key Aboriginal stakeholders prompted larger research into oral health for Aboriginal people. Two researchers, 1 Aboriginal and 1 non-Aboriginal, conducted 9 focus group discussions. A fusion of methodological paradigms —namely, Indigenous methodologies and whiteness studies. We adopted a decolonizing perspective involving Indigenous methodologies that prioritized Aboriginal people by applying their own focus, perceptions, and understandings to the research process. Aboriginal stakeholders, including one of the authors, were central to the design, implementation, analysis, and dissemination of the findings of this project. We employed an Aboriginal assistant researcher to participate in data collection, analysis, and dissemination where highlighting the voices of Aboriginal parents/ carers participants was integral to the project

(Farnbach et al., 2021)	To explore the perceptions of Aboriginal males in treatment for drug and alcohol use around their experiences accessing primary health care, and barriers to access (reasons for non-attendance)	Qualitative	20 male Aboriginal clients at a fee-paying residential drug and alcohol rehabilitation centre	Fee-paying residential drug and alcohol rehabilitation centre, Central Coast NSW. Provides 12-week residential program based on Aboriginal values and spirituality, including group counselling, one to one counselling, self-help groups and work programs.	Not defined
(Fauk et al., 2021)	To explore personal, structural, sociocultural and religious barriers to accessing MH services among African migrants	Qualitative inquiry and one-on-one in-depth interview	20 African migrants ≥18 years old (50% female; most had lived in Australia 11+ years) and 10 service providers for organisations providing services for migrants and/or refugees.	South Australia. During COVID lockdowns	Stigma and discrimination against MH problems – not seen as medical conditions and people judged by their community, especially men – seen as weak.

Inter-personal	Negative primary care experiences included inefficient health service or system processes or experience of cultural bias or racism. In addition to the racism experienced at a mainstream PHC service, one client recalled experiencing discrimination when he visited an AMS to book an appointment. Reception staff requested he provide paperwork demonstrating his "proof of Aboriginality" despite being known to them socially.	Clients without a regular GP reported experiences where reception staff (usually at mainstream PHC services) were racist towards them or "not on the same level" causing them to feel uncomfortable attending the service. Reasons for not attending PHC included: limited appointments, unable to see same GP regularly, lack of continuity of treatment or history (even with same GP), lack of access to transport, worry/fear of bad news or not understanding health info, complex life events and previous bad experiences with GPs (e.g. being passed on to D&A service for treatment).	interviews were completed by one or both male Aboriginal interviewers. Aboriginal researchers were closely involved with the research to ensure cultural perspectives were central to all stages of the research including analysis. An Aboriginal Advisory Group was convened which included staff and representatives from the residential service to oversee the project and gain an in-depth understanding of the meaning of the data. Initial Qs reviewed and modified by Aboriginal Advisory Group and researchers. Lead author is non-Aboriginal nurse. One author is an Aboriginal drug and alcohol counsellor who completed training in qualitative data collection, analysis and research processes (informed consent, study protocol). Another is an Aboriginal GP with MPH.
Interpersonal and systemic	Most of the discrimination discussed is against MH problems. MH service providers need to understand sociocultural and religious factors for some conditions.	Barriers to access and utilisation of MH services included difficulties in navigating the complexity of the health system and a lack of culturally aware service provision, sociocultural and religious factors, mental health stigma and discrimination. Women need husbands' permission to access services. Structural barriers include cost of services, long waiting times, lack of regular GPs. Mental Health stigma and shame were also reported by both migrants from across African countries and service providers as a determinant of poor access to MHSs and reluctance to discuss with service providers. Fear of disclosure and social isolation. Attitudes and behaviours of service providers, and the regular changes to service providers (i.e., different GPs and/or counsellors), were reported to influence access to MHSs among African migrants. The unsupportive attitudes of some service providers (such as asking a client to hurry up as other clients are waiting) and the lack of having the same service provider consistently to establish familiarity, influenced their unwillingness to disclose about their MH problems due to feeling rejected or unwelcome.	

(Ferdinand et al., 2015)	To examine how people from racial and ethnic minority backgrounds in four Australian localities experience and respond to racial discrimination, as well as associated health impacts.	Quantitative – survey.	1139 people ≥18 years old born in ANZ (69), Middle East (306), Africa (259), East Asia (166), South Asia (122), Pacific Islands (116), Europe (74), Americas (4)	4 LGAs in Victoria – 2 rural and 2 metro.	CALD Experiences of Racism survey – measures type of experiences X setting.	Interpersonal	36.7% reported no racism in last 12/12; 23% reported 1-5 experiences; 22% reported 6-8 experiences and 18% reported 9+ experiences. Most common were racist names, jokes or teasing, comments based on racial, ethic, cultural or religious stereotypes. Age, education, religion, gender, visibility and rurality were all significantly associated with differences in the frequency of experiencing racial discrimination	17.5% scoring over the threshold for high or very high psychological distress. People experiencing medium or high levels of discrimination were significantly more likely to be above the threshold for high or very high psychological distress compared to people who had no experiences of racism. Experiencing racial discrimination was associated with worse mental health (p=0.01). Mental health impacts were not associated with the type of discriminatory experience, but experiencing racial discrimination in shops and in employment and government settings was associated with being above the threshold for high or very high psychological distress. All types of racism can have detrimental impacts on mental health In addition to mental health implications, some of the experiences reported by respondents also have negative ramifications for physical health, including being spat on or physically assaulted.	The recruitment process included a consultation phase with relevant stakeholder groups in each council. This process was used to identify the most appropriate way of recruiting community workers and to develop data governance protocols. Community workers were trained in ethical research practices and survey administration, then distributed surveys through their personal and professional contacts as well as through local community events and functions. Surveys were administered face-to-face in group or individual sessions. In one LGA, community members were invited to complete the survey and have dinner during an event in July 2010 where 254 community members participated.
(Freeman et al., 2014)	To examine cultural respect strategies, client experiences and barriers to cultural respect in 2 health services for Aboriginal and Torres Strait Islander Australians	Qualitative – 2 case studies	22 staff interviewed (5 non-Aboriginal) + 21 clients (from 4 community assessment workshops)	1 Aboriginal community controlled health care service (ACCHCS) in Central Australia and 1 state government managed primary health care (PHC) service, in South Australia.	Focus on cultural respect = "the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples", also including access, quality of care, and equity of health outcomes. The service quality was rated from one (low achievement) to five (high achievement)	Institutional – including cultural security, cultural competence and cultural respect in organisations and health systems	Staff and clients at both services reported positive appraisals of the achievement of cultural respect. Barriers to cultural respect included cross cultural communication in areas with multiple languages, different views of health, and the language used by staff.	Both services reported experiences of racism and discrimination from mainstream services with whom they co-ordinated. The long history of (ongoing) racism towards Aboriginal and Torres Strait Islander peoples, and personal experiences of racism had led to distrust of non-Aboriginal health professionals for some clients. Authors note: "measurement of the relationship between the cultural respectfulness of care and consequent health outcomes would be methodologically extremely difficult, and was beyond the scope of this study"	Questions were developed by the research team and piloted on three practitioners and one manager (all non-Aboriginal). Four interviews were conducted by an Aboriginal researcher (Edwards). Three researchers facilitated each workshop, including one Aboriginal facilitator. Analysis of cultural respect was led by two Aboriginal researchers (Edwards and Luz) and Freeman. Findings were fed back and discussed at service staff meetings, and reports sent to clients, to share how the findings were reported back to the service.
(Fromene & Guerin, 2014)	To explore the contextual factors underlying the symptoms of Indigenous Australians' BPD diagnosis including experiences of identity, personal histories and their understanding of their mental illness.	Qualitative – informal interviews (yarning)	Indigenous Australians ≥18 years old, diagnosed with Borderline Personality Disorder (BPD) but well-stabilized with/ without medication (n = 5).	Adelaide, South Australia.	Racism was self-reported in response to questions about sense of identity, personal stories, experiences of MH services and experiences of symptoms of BPD. Discrimination was measured through participants' reports or stories of stigma against their mental health and Indigenous identity.	Interpersonal and systemic racism stemming from discrimination by the broader Aboriginal and traditional community and inpatient mental health service providers.	2 participants reported being separated from their families and placed into alternative care with white parents; 1 participant explicitly stated she was removed because she was "whiter". Every participant recalled experiences of racism or being stereotyped whether perpetuated by non-Indigenous people, other Indigenous people, health providers or non-professionals. One participant reported being discriminated by other Aboriginal people, particularly in traditional communities, for not being a "full-blood".	Experiences of racism and discrimination led to an unstable sense of identity and, and in combination with other contexts, led to the diagnoses of BPD.	Not stated.

(Gee et al., 2023)	To investigate whether a range of risk and protective factors, including cultural determinants of social and emotional wellbeing, were associated with post-traumatic stress outcomes among Aboriginal participants.	Mixed-methods: qualitative (structured interviews + focus groups) and quantitative (questionnaires + scales).	Aboriginal help-seeking participants who accessed FCS in 2011 (n = 81). 32 were interviewed in person + 49 completed the interview via a questionnaire	Melbourne, Victoria; recruited from the Family Counselling Services (FCS) unit of the Victorian Aboriginal Health Service.	Trauma due to racism and discrimination was measured by asking participants to respond to the Aboriginal Australian Version of the Harvard Trauma Questionnaire, including questions about experiences of stressful life events (such as racism) in the past 12 months.	Systemic and interpersonal racism, especially related to experiences of child removal from natural family and interpersonal trauma including family/community violence and experiences of racism.	Extent of racism not stated	A small, positive correlation between racism and trauma symptom severity (r=0.36, p<0.01), accounting for 12% of the variance in total trauma symptom severity. Experiencing two generations of child removal from one's natural family, experiences of racism, stressful life events experienced in the past 12 months, being male, and not having access to basic living expenses were all associated with greater post-traumatic stress symptom severity.	Not stated.
(Green et al., 2018)	To explore the ways in which Aboriginal carers experienced and made meaning of interactions with health, social, and education providers while accessing services and support for their child with a disability.	Qualitative – semi-structured interviews (with 12-month follow-up)	Female Aboriginal carers (n = 19) including mothers (n = 16) and grandmothers (n = 3).	NSW; recruited from Aboriginal community-controlled health service.	Experiences of racism in a healthcare, social or educational setting were self-reported by carer participants, who shed light on the complexities inherent in carers' experiences of interactions with providers and their influence on service access.	Systemic racism experienced through interactions with health, social, and education providers.	Participants perceived they were being judged by providers because they were Aboriginal and a carer of a child with a disability.	Carer participants reported that providers' cultural stereotypes, racism and lack of cultural awareness impeded access to care and services. Marginalization and lack of empowerment were apparent in carers' experiences of interactions with providers due to cultural stereotypes and racism, lack of cultural awareness and sensitivity, and poverty and homelessness. However, participants described having knowledge of health care systems (namely how to proactively interact with mainstream systems and providers) was empowering.	One member of the research team was an Aboriginal community elder.
(Haregu et al., 2022)	To estimate the prevalence of discrimination among Aboriginal and Torres Strait Islander males in Australia and examine the role of discrimination in the association between Aboriginal and Torres Strait Islander status and suicidal thoughts and depressive symptoms.	Quantitative – cross-sectional (using data collected in 2013-2014 from the baseline wave of The Australian Longitudinal Study on Male Health).	Aboriginal and Torres Strait Islander males aged 18-55 years old (n = 326).	Across Australia.	Discrimination assessed using the question "Over the past two years, how often have you experienced discrimination?" Those who responded 'very often', 'fairly often' or 'occasionally' were grouped into one category and compared against another category that combined 'rarely' and 'never'.	Interpersonal racism.	The prevalence of discrimination (39.2% vs. 19.3%) was significantly higher among Aboriginal and Torres Strait Islander males compared to their non-Indigenous counterparts.	Aboriginal and Torres Strait Islander males have a twofold higher prevalence of self-perceived discrimination (39.2% vs 19.3%, p<0.001), suicidal ideation (21.8% vs 9.4%, p<0.001) and moderate or worse depressive symptoms (24.0% vs 12.2%, p<0.001) as compared to their non-Indigenous counterparts. After adjusting for socio-demographics and substance use, Aboriginal and Torres Strait Islander status was significantly associated with suicidal thoughts (OR= 1.49, p = 0.019) and depressive symptoms (prevalence rate ratio = 1.19, p = 0.018). About 15.3% and 28.7% of the association between Aboriginal and Torres Strait Islander status, and suicidal thoughts and depressive symptoms, respectively, was explained by discrimination.	Not stated.
(Heris et al., 2024)	To explore the social determinants of health (SDOH) associated with non-smoking and never-smoking among Aboriginal and Torres Strait Islander peoples in regional Australia.	Quantitative – cross-sectional analysis (using data from the National Aboriginal and Torres Strait Islander Health Survey – NATSIHS 2018/19).	Aboriginal and Torres Strait Islander peoples ≥18 years old (n = 2274). 58.8% (n = 1337) were female and 41.2% (n = 937) were male.	Regional Australia	Discrimination was assessed by asking participants "In last 12months, had experiences of being treated unfairly because Aboriginal and/or Torres Strait Islander?" (yes/no).	Interpersonal racism.	48% of non-smokers (i.e., ex-smokers or never-smokers combined vs. current smokers) reported experiencing unfair treatment or discrimination in the last 12 months, compared to 19% of never-smokers (i.e., never-smoker vs. ex- or current smokers combined).	Significantly higher prevalence of never-smoking among people who did not experience unfair treatment (PR=1.59; 1.22–2.06) (31% vs. 19%), but difference was not significant for prevalence of not non-smoking (PR=1.12; 0.92–1.36) (54% vs. 48%). Having a usual healthcare provider (GP or AMS) was associated with non-smoking (PR=1.38; 1.02–1.86). Positive exposure to the SDOH were associated with non- and never-smoking among Aboriginal and Torres Strait Islander adults in regional Australia. Structural and systemic changes to address the SDOH, including discrimination and racism, are expected to accelerate non-smoking behaviours and improve health outcomes for Aboriginal and Torres Strait Islander peoples.	Not stated.

(Hopkins et al., 2014)	To investigate whether the profile of factors protecting psychosocial functioning of high risk exposed Aboriginal youth are the same as those promoting psychosocial functioning in low risk exposed youth.	Quantitative – cross-sectional data (using data from the Western Australian Aboriginal Child Health Survey – WAACHS 2000-2002)	Aboriginal youth aged 12-17 years old (n = 1021), 50% were male.	Western Australia	Racism was self-reported by participants in response to a survey question on *perceived racism:* "In the past 6 months, have you ever been treated badly or refused service because you are Aboriginal?" (yes/no).	Interpersonal or systemic racism.	Not measured.	Youth reporting not being exposed to racism were more than twice as likely as those exposed to racism to have good psychosocial functioning (OR 2.09, 95% CI 1.17, 3.74, p = .02).	Not stated.
(Hosseini et al., 2017)	To investigate the association between levels of depression, socio-demographic and migration variables, and the role of resilience as a mediator between these features.	Quantitative – cross-sectional study	First generation Iranian immigrants ≥18 years old (n = 182). 46% female and 54% male.	Across Australia	Migration and Settlement Questionnaire (MASQ). Discrimination measured by two items: how much discrimination participants had personally experienced against them while living in Australia (none, a little, quite a lot) + reasons they thought they were subjected to discrimination (nationality, culture, religion, and not applicable).	Interpersonal discrimination through personal experiences of discrimination and perceived reason for being discriminated against.	Extent of discrimination was not measured independently.	Higher levels of discrimination were significantly correlated with higher levels of depression (r = 0.15, p = 0.046). A small but statistically significant negative correlation also was found between discrimination and resilience (r = −0.17, p = 0.019); resilience was lower in participants who had experienced higher levels of discrimination compared to participants who had experienced moderate levels of discrimination (MD = 0.19, p = 0.3; [−0.38, 0.01]). Statistically significant correlations also were detected between discrimination and marital status (r = 0.16, p < 0.05); discrimination and education (r = −0.22, p < 0.05); marital status and education (r = −0.33, p < 0.05).	Not stated.
(Islam et al., 2022)	To investigate the relationship between bullying victimization and oral health problems by remoteness.	Quantitative – prospective cohort study (using data from LSIC)	Australian Indigenous children aged 10-15 years old (n = 766).	Across Australia	Racial discrimination self-reported by either children or parents: "How often does your family experience racism, discrimination, or prejudice?" (frequently or occasionally/ never).	Interpersonal discrimination experienced through bullying victimization.	48.8% of Indigenous families had experienced racial discrimination, where 40.9% of them were living in major cities and 59.1% were in the rural/remote areas.	Findings from parent data shows that children in major cities who had any dental problem were 2.20 times (95% CI, 1.20–4.02) more likely to be bullied than those who had no dental problems. From child data, it was found that children with poor oral hygiene were significantly (OR 2.33, 95% CI, 1.41–3.86) associated with bullying in rural/remote areas. In contrast, from the parent data, bullying victimization was significantly associated with families who experienced racism regardless of location (major cities: OR 3.27, 95% CI, 1.70–6.29; rural/remote: OR 2.39, 95% CI, 1.58–3.63) compared to their counterparts.	Not stated.
(Jamieson et al., 2023)	To investigate the cumulative effect of two forms of oppression on Indigenous Australians oral health inequities.	Quantitative – observational study	Indigenous Australians ≥18 years old (n = 1011).	South Australia; in Aboriginal Community Controlled Health Organisations.	Measure of Indigenous Racism Experiences (MIRE), assessing experiences of interpersonal racism across 9 mutually exclusive settings including health services: "In the last 12 months, have you felt that you have been treated unfairly in any of the following ways because of your racial or ethnic background?". 6-point scale ('strongly disagree' to 'strongly agree')	Interpersonal racism.	Over half (52%) had experienced racism in the past 12 months in one or more setting and 85% had experienced one or more negative life events.	Participants who had experienced both racism and negative life events (46%) reported difficulty paying a $100 dental bill (47%). The prevalence of fair/poor oral health among those who had experienced most oppression (both racism and negative life events) was over 7 times that of participants who had experienced the least oppression (no racism and no negative event) (54.3% vs 7.7%). The same held true for mean OHIP-14; participants who had experienced both racism and one or more negative life events had a 5 point higher mean score than participants experiencing no racism and no negative life event (19.6 vs 14.3).	Data was collected by trained Indigenous research officers.

(Jennings et al., 2023)	To explore the acceptability and appropriateness, features of value, and opportunities for improvements in the Better Cardiac Care (BCC) model for Aboriginal and Torres Strait Islander patients, from the perspective of patients and their family members.	Qualitative – informal interviews (yarning)	Aboriginal Australians (n = 16).	Brisbane, QLD	Not specifically defined.
(Kelaher et al., 2014)	To examine the experiences of racism in health settings and their impact on mental health among Aboriginal Australians.	Quantitative – cross-sectional survey	Aboriginal Australians ≥18 years old (n = 755).	Victoria	Racism was self-reported by participants. Qs included items on interpersonal racism (e.g. teasing, being ignored, treated as less intelligent) and settings in which racism was experienced (e.g. local council, shops, sport events and health settings).
(Kendall et al., 2020)</ electronic-resource-num></ record></ Cite></ EndNoteC	To explore incarcerated Aboriginal women's experience of accessing healthcare and the impact on their health outcomes.	Qualitative – semi-structured interviews	Aboriginal women (n = 43)	Urban and regional prisons, NSW	Not specifically defined.
(Macedo, Smithers, Roberts, Haag, et al., 2019) **"Does ethnic-racial identity modify the effects of racism on the social and emotional wellbeing of Aboriginal Australian children?"**	To investigate the protective role of ethnic-racial identity (ERI) affirmation on longitudinal association between racism and Aboriginal Australian children's social and emotional wellbeing.	Quantitative – cross-sectional study (using data from LSIC)	Aboriginal children aged 7-10 years old (n = 408)	Across Australia	Caregivers self-reported discrimination: "Has study child been bullied or treated unfairly at school because he/she is Aboriginal and/or Torres Strait Islander?". Answer options: "Yes, bullied (kids being mean to him/her)", "Yes, treated unfairly (adults being mean to him/her)", "Yes, both bullied and treated unfairly", + "No".
(Macedo et al., 2020) **"Racism, stress, and sense of personal control among Aboriginal Australian pregnant women"**	To explore racism experiences in the past year and investigate a causal association between racism, stress, and sense of personal control among pregnant Aboriginal women.	Quantitative – cross-sectional study (using data from a randomized controlled trial to prevent early caries in children)	Pregnant Aboriginal women (n = 369)	South Australia	MIRE items: "In the last twelve months, have you felt that you have been treated unfairly in any of the following ways because you are Aboriginal?" in 9 settings (e.g. applying for work or at work, at home, or by staff of government agencies) (yes/no).

Systemic racism from previous experiences in the health system.	Participants disclosed life stories and lived experiences including, facing health authorities who have acted in an oppressive and discriminatory manner; experiences of family separation and loss due to the ongoing trauma of the Stolen Generations; everyday experiences of racism, judgement, discrimination, denial of healthcare, and loss and grief due to premature morbidity were common.	Previous experiences of racism and discrimination negatively impacted participants' health and wellbeing and contributed to a guarded receptiveness to BCC. For example, one participant recounted having three heart attacks in five years but being denied any medical intervention by the cardiac surgeon. He felt labelled as a smoker and judged as not being worthy of quality, life-saving medical care. Being *'made to feel not worthy'* was echoed across other participants' stories of judgement and exclusion in healthcare.	One research officer (SE) identified as Indigenous.
Interpersonal racism.	Nearly all participants (97%) reported at least one racist incident in the preceding 12 months. 221 participants (one third of the sample) reported experiencing racism in health settings in the past 12 months of which 52% reported being a target of racist names, jokes or teasing, or being stereotyped; 10% were told they *"Didn't belong in Australia"*.	People experiencing racism in health settings (OR, 4.49; 95% CI, 2.28–8.86) and non-health settings (OR, 2.66; 95% CI, 1.39–5.08) were more likely than people who did not experience racism to be above the threshold for high or very high psychological distress.	Not stated.
Systemic racism and discrimination stemming from inequitable healthcare, stereotyping, and being ignored.	Aboriginal women reflected they did not receive the same treatment as non-Indigenous women in prison or in the community as they faced stereotyping, being judged prejudicially, and receiving differential poorer treatment.	Aboriginal women experienced being stereotyped as active drug seekers, as a result they described that healthcare decisions were based on this stereotype, rather than on their actual symptoms or requests, and they consequently were not able to access healthcare for the same health problems as non-Indigenous women. Therefore, inequitable access to culturally safe healthcare and institutional racism reinforces health disparities and negative physical and mental health outcomes.	Not stated.
Interpersonal discrimination experienced through interactions with other students and/or school authorities.	Approximately 15% of children were reported to have experienced racism at school and between 15% and 22% of the children presented difficulties in any of the investigated SEWB domains.	Children exposed to racism and with low ERI affirmation were at increased risk of hyperactive behaviour (RRa 2.53, 95% CI 1.17, 5.48), conduct problems (RRa 2.35, 95% CI 1.07, 5.15), and total difficulties (RRa 1.73, 95% CI 0.84, 3.55). However, among the children with high ERI affirmation, experiencing racism was associated with an 80% higher risk of presenting peer problems (RRa 1.80, 95% CI 0.83, 3.90). The adjusted risk ratios show that the risk of total behavioural and emotional difficulties due to exposure to racism was of 18% (RR 1.18, 95%CI 0.72, 1.94) when compared to children not exposed.	Not stated.
Interpersonal and systemic racism such as when applying for jobs or interacting with neighbours or at somebody else's house.	Nearly half (48.3%) reported at least one experience of racism in the previous year and almost one third (31.8%) reported racism occurring in a public setting.	Stress scores increased by 0.69 for each one unit increase in number of settings where racism was experienced (β = .69, 95% CI 0.36, 1.01). The unadjusted model for the effect of racism on sense of personal control indicated that one unit increase in racism experiences was associated with a decrease of 0.39 on the sense of personal control score (β = −.39, 95% CI −0.71, −.0.07).	Data was collected by an Aboriginal research officer.

(Macedo, Smithers, Roberts, Paradies, & Jamieson, 2019) **"Effects of racism on the socio-emotional wellbeing of Aboriginal Australian children"**	To estimate the effect of racism on indicators of Australian Aboriginal child socio-emotional wellbeing (SEWB) at 1-2 years after exposure.	Quantitative – cross-sectional study (using data from LSIC)	Aboriginal children aged 6-12 years old (n = 1060)	Across Australia	Caregivers self-reported discrimination by answering the question: "Has study child been bullied or treated unfairly at school because he/she is Aboriginal and/or Torres Strait Islander?". Answer options were "Yes, bullied (kids being mean to him/her)", "Yes, treated unfairly (adults being mean to him/her)", "Yes, both bullied and treated unfairly", "No", "Don't know", and "Refused".	Interpersonal discrimination experienced through interactions with other students and/or school authorities.	Rates of racism reported as 15.3% in K Cohort (Child Cohort) and 14% in B Cohort (Baby Cohort).	Exposure to racism was associated with an adjusted point estimate indicating a 41% increased risk for total emotional and behavioural difficulties.	Not stated.
(Mahadevan & Jayasinghe, 2022)	To examine the correlation of post-migration factors and parental mental health with post-traumatic stress disorder and happiness levels of adolescent refugee migrants in Australia.	Quantitative – population-based cohort study (using the Building a New Life in Australia dataset)	Adolescent refugee migrants aged 11-17 years old (n = 356)	Not stated.	Discrimination was self-reported by adolescent participants (rather than their caregivers): "In the last 6 months have you been treated unfairly or badly because of your language or accent; skin colour; religious beliefs/cultural background?" (yes/no)	Interpersonal racism.	Over 85% participants have experienced some form of discrimination.	The findings reported discrimination related to religion/culture and language is correlated with only the younger boys' PTSD while the latter is correlated with only the younger girls' PTSD. While discrimination due to skin colour is associated with the PTSD scores of younger girls, it has no association with the PTSD of the older girls or boys.	Not stated.
(McCabe et al., 2016)	To examine the health behaviours, enablers and barriers to health behaviours among Indigenous Australian men.	Qualitative -semi-structured interviews	Indigenous Australian men aged 18-35 years old (n = 150)	Broome, Western Australia, Mildura, regional Victoria, and Melbourne, Victoria.	Participants self-reported and shared stories on their experiences of racism and discrimination, and its negative impact on their health.	Interpersonal racism.	Many Indigenous men reported having experienced discrimination and racism which negatively impacted their health.	Some participants reported racism contributed to the alcohol and drug problems in the Indigenous community. Others had experienced racism in sport which led them to quit and subsequently engage in unhealthy behaviours. Participants reported that negative stereotypes of Indigenous men being lazy, drunk, and violent affected their employment prospects and opportunities to participate in healthy behaviours such as playing sports or engaging with health services.	Not stated.
(McCormack et al., 2024)	To explore under-standings of appropriate and accessible sexual healthcare that would meet the needs of LGBTQ+ Aboriginal youth and inform the development of age and culturally appropriate sexual health services.	Qualitative -semi-structured interviews	LGBTQ+ Aboriginal youth aged 16-24 years old (n = 10)	New South Wales	Not specifically defined.	Interpersonal discrimination from health providers.	1 participant described an intersection of racism and sexism targeted at young Aboriginal women: 'it's just, like, "all they're good for is getting pregnant"'. Another participant (bisexual woman) described a typical sexual health consultation as focused on her intimacy with men and felt health providers made assumptions based on racist stereotypes: 'stereotypes of like, "oh, we've gotta prevent Aboriginal communities from having kids too early and too young"'.	Fear of seeking sexual health advice due to the stigma around sexual health, previous negative experience with provider, and judgment or racist stereotyping from providers.	The majority of interviews were conducted by two young Aboriginal peer research assistants and one older, male Aboriginal research assistant.

(McEwen et al., 2022)	To investigate whether moral injury appraisals moderated the relationships between trauma, post-migration living difficulties, resilience, and mental health outcomes in adolescent refugees.	Quantitative – cross-sectional correlational	Adolescent refugees (n = 85)	Across Australia	The Everyday Discrimination Scale asked participants how often they experience routine, minor acts of discrimination - 10 acts rated from "never" to "almost every day". Those experiencing discrimination were asked for possible (e.g. gender, race, age, other reason).	Interpersonal racism experienced day-to-day.	Males reported significantly greater discrimination, t(84) = 2.40, p = 0.02 than females.	A significant interaction was found between moral injury and discrimination for externalizing symptoms $R^2\Delta = 0.07$, F(1, 81) = 9.75; p = 0.0025 and PTSD symptoms, $R^2\Delta = 0.08$, F(1, 81) = 8.92; p = 0.004. Adolescents who had experienced high levels of discrimination combined with high levels of moral injury had poorer mental health outcomes.	Not stated.
(Menzies et al., 2020)	To explore the major barriers to, and facilitators of, influenza vaccination among Aboriginal adults.	Mixed-methods: qualitative (focus group) and quantitative (cross-sectional survey).	Aboriginal Immunisation Healthcare workers from the focus group (n = 13) and Aboriginal Australians ≥18 years who completed the survey (n = 273)	NSW	Not specifically defined.	Systemic racism in health services.	8% of survey respondents reported being discriminated against.	Focus group participants reported identification of Aboriginal patients was difficult in areas where an Aboriginal Medical Service was not available as Aboriginal community members "fear getting in trouble" for identifying as Aboriginal. Therefore, it became difficult to determine whom to offer certain vaccines to. Survey respondents who reported feeling unsafe or discriminated against did not have any difference in vaccination status (p=0.74).	All interviewers were Aboriginal Health Workers.
(Mithen et al., 2021)	To explore patient experiences of hospitalization and to identify strategies to improve equity in health care for Aboriginal patients.	Mixed-methods: single-centre, prospective study (interview and survey data) combined with retrospective medical chart audit	Aboriginal patients completed patient experience surveys (n = 73) and had chart audits (n = 68) (patient overlap was permitted and may have occurred); semi-structured interviews with Aboriginal interpreter staff (n = 4).	Northern Territory	Not specifically defined.	Systemic discrimination in the hospital setting.	One survey respondent commented that non-Aboriginal patients were allowed more freedom and less likely to be admonished for smoking on hospital grounds, while Aboriginal patients were subjected to racist remarks from both clinical and non- clinical (i.e., security guards) hospital staff. From the medical chart audit, language and interpreter requirement was documented for only 44% of patients of which seven charts were documented incorrectly (e.g., Bakkada instead of Burarra language) and six charts were documented plainly as "local language" or "Aboriginal language".	Only 35 survey respondents (48%) stated that treatment was explained clearly by doctors and hospital staff, attributed in part to discrimination and a lack of staff understanding and support for patients' cultural obligations, leading to impaired communication between providers and patients.	Patient experience data were collected by two female Aboriginal researchers.
(Mohamed Shaburdin et al., 2022)	To highlight how barriers to care exist in patient-provider interactions, specifically racial micro-aggression, and explore how language is used by health providers.	Qualitative – semi-structured interviews	Health professionals (n = 21) – ethnicities not ascertained	Victoria (recruited from two rural health services)	Not specifically defined.	Systemic discrimination against patients in the health setting.	On the topic of First Nations patients disengaging from the health service, one participant said that 'yes they do disengage, I think because a lot of that, it's that shame-shy thing that gets in the way'. Rather than the provider genuinely engaging with the perceived 'shame-shy thing', the provider problematised the culture(s) of patients by excusing the disengagement as culturally and by default racially contingent.	Participants shared stories of inaction, discomfort and at times relegating the 'difficult' patient to a culturally-appropriate specialist service due to the needs of their patients from Indigenous, immigrant or refugee backgrounds. This impacted the extent of care patients were able to receive from providers. For example, 'we don't have expertise in that [a patient's culture]', which dismissed the patient's needs by suggesting that the generalist service could not assist those identified from a non-dominant cultural background.	One researcher is First Nation Australian.
(Nguyen et al., 2024)	To examine what factors are associated with psychological distress in refugees resettled in Australia.	Quantitative – population-based longitudinal study (using the Building a New Life in Australia data set)	Refugees ≥18 years old (n = 1881)	Not stated.	Exposure to discrimination was assessed with 1 item: "In the last 12 months, do you think you have been discriminated against, stopped from doing something, or been hassled or made to feel inferior, because of your ethnicity, religion or skin colour?" (yes/no).	Interpersonal discrimination	4.1% of participants reported having experienced discrimination.	Experiencing discrimination and poorer English proficiency were associated with increased risk of elevated psychological distress over time.	Not stated.

(O'Rourke et al., 2022)	To identify the spatial requirements and design features of healthcare facilities that will improve Indigenous participation in health services.	Mixed-methods: quantitative survey data and semi-structured interviews.	Aboriginal and Torres Strait Islander survey respondents (n = 602) and interviewees (n =55). 21 interviewees were selected from the survey group.	North Queensland	Not specifically defined.	Interpersonal racism from strangers in the waiting room.	One participant described being discriminated against in the waiting room: "The eyes roll or the lip goes up. I see people move to another section.". Another participant, who was pregnant at the time, experienced being stared at in the waiting room.	Racism and shame due to experiencing discrimination in the waiting room was a common reason for participants to avoid healthcare facilities until acutely ill.	Not stated.
(O'Donnell et al., 2023)	To explore the change in psychological distress over a 5-year period among refugees resettled in Australia.	Quantitative – population-based cohort study (using the Building a New Life in Australia data set)	Refugees aged 15-75 years old (n = 2399)	Not stated.	Discrimination was measured with a single item: "Have you been discriminated against, stopped from doing something, been hassled, or made to feel inferior, because of your ethnicity, religion, or skin colour in the preceding 12 months?" (yes/no).	Interpersonal discrimination	Extent of discrimination was reported via different categories of psychological distress: (1) resilient, 3.7%; (2) deteriorating, 5.5%; (3) recovering, 8.3%; (4) clinical, 6.7%.	Recovering and deteriorating psychological distress was marked by greater perceived discrimination and lower positive context of reception (i.e., whether participants had been made to feel welcome in Australia).	Not stated.
(Omar et al., 2017)	To examine Horn of Africa Muslim men's understanding, experiences and views on the causes of emotional difficulties and accessibility of mental health services.	Qualitative – focus-group interviews	Horn of Africa Muslim men ≥18 years old (n = 36)	Victoria	Not specifically defined.	Perceived interpersonal and systemic racism.	Perceived discrimination because of skin colour, religion and Islamic names were identified as obstacles to employment and negatively affected mental and emotional wellbeing.	Emotional difficulties and negative mental health were attributed to immigration and settlement-linked stressors including racism and unemployment due to racism. Prolonged unemployment was seen as a pathway to drugs and gambling, ultimately resulting in mental problems.	The main author is a Horn of Africa man.
(Oribin et al., 2024)	To explore emergency department healthcare providers' experience and perceptions of the factors surrounding a patient's decision to discharge against medical advice (DAMA).	Mixed-methods: quantitative (survey) & qualitative (semi-structured interviews)	Healthcare providers: surveys (n =19) and interviews (n = 14) were selected from the same sample. Ethnicities: Caucasian (n = 6), Asian (n = 6), Aboriginal Australian (n = 2) & others (n = 5).	Queensland	Not specifically defined.	Systemic racism in a hospital setting.	Not measured.	Most participants reported the strongest influence on DAMA events included a lack of culturally sensitive healthcare services (94.7%), stereotyping (78.9%), language barriers (73.7%) and racism and intimidation (68.4%).	Not stated.
(Pittaway & Dantas, 2024)	To explore how South Sudanese young people respond to the narrative in the media about 'African Gangs' and how this impacted their personal experiences of racism.	Qualitative – interviews	South Sudanese Australians aged 14-21 years old (n = 23).	Victoria	Racism is the use of discrimination, prejudice or antagonism that can occur by either an individual, a community or a system, that is directed at a marginalized person or group, and is based on ethnicity, culture and community (AHRC).	Interpersonal racism; systemic racism by child protection and human services departments.	Media portrayal promotes sense of being observed and under suspicion by community; police harassment. Most stated "ongoing racism as a daily occurrence". Two participants reported being stereotyped as being part of an 'African Gang' when they gathered with friends socially.	Literature states that alienation of Sudanese youth based on their race negatively impacted education, employment, housing and health outcomes, further burdening health, legal and welfare systems, contributing to social inclusion. Cultural views of mental illness often relate it to being cursed or the result of police action. Distrust of MH support agencies among youth and their parents, so South Sudanese youth with poor MH do not seek help. Despite cultural stigma, it is real concern for participants. "Many made comments about feeling 'sad', 'depressed', 'down', 'tired' or full of 'anxiety'. With the cultural barriers to seeking mental health treatment and the compounding factors of racism, receiving negative media representations and having difficult experiences with police, the impacts of mental health are highly prevalent" (189)	Not stated.
(Poirier et al., 2022)	To understand how neoliberal subjectivity exists for Indigenous peoples in the context of oral health in Australia.	Qualitative – interviews	Mothers pregnant with an Indigenous child (n = 177)	South Australia	Not specifically defined.	Systemic racism	31 participants experienced institutional racism.	Institutional racism (e.g., implicit bias, unhelpful assumptions) in the health setting impacted participants' willingness or ability to make and attend dental appointments, therefore it was a barrier to accessing dental healthcare.	The interviewer was a senior Indigenous researcher.

(Polonsky et al., 2018)	To explore how refugees' acculturation, perceptions of discrimination, past behaviour, objective knowledge and medical mistrust affect their health inclusion, in the case of blood donation.	Quantitative – cross-sectional survey	African refugees (n = 317)	Victoria & South Australia	Perceived discrimination due to ethnic background in different social settings (e.g., work, school, public). Another item asked participants if they felt they were "not wanted in Australian society".	Interpersonal and systemic racism.	Not stated.	Participants' perceived discrimination contributed to medical mistrust, which indirectly, negatively affected blood donation intentions (β = -.08, p = .00).	Not stated.
(N. Priest et al., 2020)	To investigate the prevalence of racial discrimination experiences from peer, school and societal sources among school students, and examine associations between these experiences and socio-emotional and sleep outcomes.	Quantitative – population-based cross-sectional study (using data from the Speak Out Against Racism study)	Students aged 10-15 years old (n = 4664).	NSW and Victoria	Racial discrimination assessed using 10 items from the Adolescent Discrimination Distress Index and 2 items previously used with diverse Australian school students: discrimination by school peers (4 items), school personnel (3) and by societal perpetrators (5). Also perceived reason for being discriminated against (e.g., because of your race/ethnicity?)	Interpersonal and systemic discrimination particularly in the school setting.	41.56% (95% CI 36.18 to 47.15) of students reported experiences of direct racial discrimination including direct experiences from peers (32.40%; 95% CI 28.60 to 36.43), school (12.94%; 95% CI 10.76 to 15.48) and societal (27.52%; 95% CI 23.79 to 31.59) sources. Across all sources of discrimination, a greater proportion of Indigenous and ethnic minority students reported direct racial discrimination than their Anglo/European counterparts.	Findings suggested direct and vicarious discrimination had an effect on sleep (for sleep duration, total direct: beta=−21.04, 95% CI −37.67 to −4.40; vicarious: beta=−9.82, 95% CI −13.78 to −5.86). Vicarious racial discrimination was associated with increased socioemotional difficulties and shorter sleep duration, longer sleep latency and increased sleep disturbance.	Not stated.
(Priest et al., 2014)	To investigate the moderating effects of vicarious racism and motivated fairness on the association between direct experiences of racism and mental health outcomes among primary and secondary school students.	Quantitative – population-based cross-sectional survey	Students aged 8-17 years old (n = 263).	Victoria	Racial discrimination assessed via 7 items examining direct experiences and 3 items examining vicarious experiences toward other students.	Interpersonal and systemic discrimination particularly in the school setting.	Participants reported experiencing at least one form of racism directly (32.2%); at least one form of direct racism every day (22.1%); vicarious racism (71.7%); all three forms of vicarious racism (26.3%); at least one form of vicarious racism every day (47.3%). For direct racism, the most common experience reported was students being told they didn't belong in Australia (19.5% at least monthly). For vicarious racism, students most commonly reported others being called names or teased because of their cultural group (65.7% monthly or more). Those reporting direct racism were much more likely to also experience vicarious racism (OR 9.95; 95 % CI 2.23–44.31, p < 0.01)	Direct experiences of racism were robustly associated with higher levels of loneliness (adjusted OR 4.13; 95 % CI 1.62–10.53, p < 0.01) and depressive symptoms (adjusted OR 3.60; 95 % CI 1.26–10.27, p < 0.05) in multivariate regression models.	Not stated.
(Naomi Priest et al., 2020)	To examine associations between self-reported racial discrimination and cardio-metabolic risk markers among school students.	Quantitative – population-based cross-sectional study (using data from the Speak Out Against Racism study)	Students aged 10-15 years old (n = 124) of which most identified as Indigenous or CALD (n = 79).	NSW and Victoria	Racial discrimination assessed using 10 items from the Adolescent Discrimination Distress Index and 2 items previously used with diverse Australian school students: discrimination by school peers (4 items), school personnel (3) and by societal perpetrators (5)	Interpersonal and systemic discrimination particularly in the school setting.	47% of Indigenous or CALD participants reported two or more experiences of racial discrimination, significantly greater than their Anglo/European counterparts (13%).	Two or more reported experiences of racial discrimination were associated with increased BMI z-score (b 0.58, 95% CI 0.18, 0.99), waist circumference (b 4.91 cm, 95% CI 0.71, 9.1), systolic blood pressure (b 2.07 mmHg, 95% CI 0.43, 3.71) and IL-6 (b 0.13, 95% CI 0.00, 0.27).	Not stated.
(Radhamony et al., 2023)	To explore the perspectives of people from CALD communities on mental health services.	Qualitative – telephone interviews	CALD participants (n = 21)	Victoria	Not specifically defined.	Interpersonal discrimination against themselves and vicarious discrimination toward friends or colleagues. The negative stigma around mental illness was cause for being discriminated by the ethnic community.	Not explicitly measured.	The stigma around mental illness existed more so in participants' communities and country of origin than in Australia, therefore they found it difficult to openly access mental health services, prolonging their isolation and worsening their mental illness. Negative migration experience and discrimination contributed to poorer mental health outcomes.	Not stated.

(Rheault et al., 2021)	To examine the perceptions and experiences of Aboriginal and Torres Strait Islander adults regarding chronic disease education, and how they self-manage their health.	Qualitative – semi-structured interviews (yarning)	Aboriginal and Torres Strait Islander adults ≥ 18 years old with a diagnosis of a chronic disease/s (n = 20)	Queensland	Not specifically defined.	Systemic discrimination	Participants voiced their frustration at the lack of healthcare for Indigenous Australians in previous generations, resulting in poor chronic disease management. They described that the current Australian adult Indigenous generation is the first generation to experience freedom which they described as having access to education opportunities of their own choice, marriage without requiring permission, land rights and more.	The lack of culturally appropriate healthcare in the community setting for Indigenous Australians has subsequently led to poor chronic disease management in Indigenous patients.	Not stated.
(Rix et al., 2015)	To explore the perspectives of Aboriginal patients' and healthcare providers' experience of renal services.	Qualitative – interviews (yarning)	Aboriginal patients receiving hemodialysis aged 35-78 years old (n = 18)	Rural NSW	Not specifically defined.	Systemic discrimination in the health setting.	A theme that emerged from the interviews was *managing patient fear of mainstream services* as several participants described fear being driven by experiences of family members on dialysis and a history of racist treatment by government organisations.	Fear of mainstream services stemmed from hearing about negative experiences from family members on dialysis, mistrust in health and government services, and lack of cultural awareness among health providers, resulting in avoidance of hospitals and delayed diagnosis/ commencement of hemodialysis treatment.	Not stated.
(Robards et al., 2019) eatures"}}	To understand health system navigation, including the role of technology, for young people belonging to one or more marginalised groups, in order to inform youth health policy in New South Wales, Australia.	Qualitative longitudinal study with 2–4 interviews each over 6 to 12 months living in NSW. The analysis used Nvivo software and grounded theory.	Marginalised young people aged 12–24 years (n = 41). 21 rural 20 sexuality and/or gender diverse 9 homeless 5 refugee 5 Aboriginal participants	NSW. One phase of the 4-phase Access 3 project that explored barriers to health care and health system navigation.	"Cultural issues salient with refugee and Indigenous young people" were self-reported through these qual interviews. N	Personal and systemic	Participants reported discrimination due to cultural background	Experiences and perceived experiences of discrimination impacted access to health services	A group of Youth Consultants, (young people from marginalised backgrounds employed to advise about the study) provided advice via email and group meetings on the survey instrument, recruitment methods, interview questions, interpretation of findings, policy translation and dissemination.
(Rusinga et al., 2024)	Non- Indigenous, Black people's perspectives of physical therapy in Australia Exploring power asymmetries and structural inequities (racism)	Qualitative – semi structured interviews	12 culturally and linguistically diverse participants	Australia (nationwide)	Discrimination and structural racism defined as the compounding impacts of cultural norms, policies and practices the produce inequity (pp. 2) Self-reported in interviews based on personal experiences. Critical Race Theory and critical discourse analysis used as analytic frameworks	Interpersonal and systemic	Experiences and perceptions of racism	Systemic barriers to accessing physical therapy Resulted in 2 discourses: Physio is a solution for white people (western principles of medicine) with little consideration of other cultural practices Physios are white (practitioners are of western origin). Lack of Black physical therapists impacts cultural safety and comfort when accessing physical therapy. Black people's engagement with physical therapy was also affected by the intersections of systemic racism and social inequities such as low income and language barriers.	The research team comprises 2 qualified physical therapists and 2 final year physical therapist students—3 are female and 1 is nonbinary. A.R. is a Zimbabwean-Australian who identifies as Black, S.J. is a Singaporean who identifies as Asian, N.C. is a Brazilian who identifies as Black, and J.S. is a white Australian.

(Sahdra et al., 2020)	To explore discrimination related frame of reference effects in overlapping friendship groups of ethnically diverse youth. Research question: To what extent is the frame of reference of overlapping friendship communities important for young people's feelings of discrimina- tion and subjective well-being? That is, do youth feel better or worse to the extent that they feel less or more discrimination than their friends?	Cross-sectional	898 students in Years 7-12: White Australians (*n* = 420), Indigenous Australians (*n* = 174), and Other Australians (*n* = 277) Low SES	3 schools in NSW	Felt discrimination: perceived discrimination against one's cultural background. Measure adapted from King et al. (2007) with 4 questions: "I have been discriminated against in education because of my cultural background," "Sometimes I feel that I am being talked down to because of my cultural background," "I have been discriminated against by the police because of my cultural background," "I would have had better chances in life if I had come from a different cultural background." Measure by 5-point scale (1 *Strongly disagree* to 5 *Strongly agree*).	Personal, systemic, structural potentially institutional	Relative to Whites, Indigenous and other minority Australians reported greater discrimination against their group. Extent not stated.	Felt discrimination did not correlate with mental ill health – 3 groups comparable in mental health and subjective well-being measures	At least one Indigenous author Also, university department named as Australian Institute of Indigenous Thriving
(Saxby et al., 2024)	To examine health outcomes for Indigenous and non-Indigenous Australians according to levels of opposition to the Voice. To explore how community-level attitudes influence Indigenous health outcomes or disparities relative to non-Indigenous people	Quantitative	17 000 participants. Data from Household, Income and Labour Dynamics in Australia (HILDA) survey	National, Australia	Used regional results from Australia's national referendum to establish an Aboriginal and Torres Strait Islander Voice to Parliament ('the Voice') as a proxy for attitudes to Indigenous Australians. Opposition to the Voice = proportion of population voting No at SA3 statistical level.	Structural, interpersonal and community level	61% of Australians voted against the Voice. Analyses of voting responses suggest that those voting 'no' were more likely to be male, have lower levels of education, and lower household incomes. Aboriginal and Torres Strait Islander peoples were more likely to vote yes than non-Indigenous Australians.	Racism is associated with negative health outcomes among Aboriginal and Torres Strait Islander 'Indigenous' peoples. Correlations made from algorithms based in self-reported survey responses "There is evidence of widening Indigenous health disparities in regions with higher opposition to the Voice, compared to non-Indigenous Australians, in areas with the highest opposition to the Voice. However, in areas with the lowest opposition to the Voice (Q1), the proportion of Indigenous and non-Indigenous Australians with poor mental health was similar (p.6.)" This indicates racism or community feelings towards Indigenous peoples could be directly related to health outcomes. "We find that Indigenous peoples living in regions of Australia with higher levels of opposition to the Voice experience poorer health outcomes, are less likely to access healthcare, and more likely to engage in risk- taking behaviours, such as smoking and binge drinking. We also find that stronger opposition to the Voice appears to have little, to no, association with these same health behaviours and outcomes for non-Indigenous Australians" (p.8).	At least one Indigenous author

(Schuch et al., 2021)	To estimate the prevalence of perceived racial discrimination in Australia, its association with oral health impairment, and to examine whether this association was more severe among low socioeconomic status (SES) groups.	Quantitative-cross-sectional population-based 2013 National Dental Telephone Interview Survey and follow up paper-based survey	People aged ≥ 18 years who completed phone interview and follow-up survey. N=2798. Demographics similar to Australian population.	National, Australia	Perceived racial discrimination assessed with a modified sub-scale of MIRE questions that measured inter-personal racism across 10 settings. The number of settings where racism reported were grouped: 'none', 'one or two' 'three or more settings'.	Interpersonal Structural racism	11% reported racial discrimination in the past 12 months. Frequent (3+ settings) racial discrimination was reported by 5% of the participants, while 6% reported racial discrimination in 1 or 2 settings.	Prevalence of oral health impairment was 53.2% among individuals who reported racial discrimination vs 38.1% among those who did not. The higher the number of settings or life domains in which discrimination was perceived, the higher the prevalence of oral health impairment. Adjusted prevalence ratios for participants who reported racial discrimination were: oral impairment 1.39 (95% CI 1.12-1.73); toothache 1.38 (0.92-2.09); discomfort due to mouth appearance 1.50 (1.12-2.01); food avoidance due to oral health 1.43 (1.00; 2.05). Those who reported racial discrimination in 1-2 settings had a 33.5% higher prevalence of oral health impairment compared to their peers not perceiving discrimination. Among those who reported racial discrimination in 3+ settings, the prevalence of oral health impairment was 46% higher than the reference group. Not only is racial discrimination a widespread form of inequality in Australia, but also low-SES individuals bear a greater burden of the potentially harmful oral health effects of this damaging social construct. Among high income people, prevalence ratio for those who reported racial discrimination in at least 1 setting was 1.17 (0.76-1.80); among low-income people the ratio was 2.00 (1.54-2.59).	Indigenous authors named
(Shahid et al., 2016)	To examine/ identify factors that contribute to delayed diagnosis of cancer among Aboriginal Australians.	Qualitative – in-depth open-ended interviews. Health service provider interviews occurred at 2 time points 2006/07 and 2011. Aboriginal participant interviews all conducted face to face	Aboriginal health patients and family members n=30. 14 patients/ survivors + 16 family members. 19 remote + 11 urban. Health service providers n= 62. 10 were AHWs and 17 of the 62 identified as Aboriginal.	Western Australia. Perth and 6 rural/ remote regions in WA	Qualitative methods were designed to understand rather than measure. Aboriginal participants described experiences with cancer and cancer services, with specific interview probes on diagnosis, treatment and follow-up.	Personal attitudes/ interpersonal racism	Institutional distrust based on previous knowledge and experiences of racism Lack of culturally safe environments in healthcare services and cancer treatment.	Three broad themes of factors were identified: one of which included "Contextual factors such as intergenerational impact of colonisation and racism and socioeconomic deprivation have negatively impacted on Aboriginal Australians' trust of the healthcare professionals" *"When you talk about the hospital system, I can say, yes … we've been into some of the units at hospitals where you are just looked at—I know that when my sister was having her treatment, we would walk into the chemo unit, being the only three Aboriginal people there, her, myself and her husband, you would have a lot of white people sitting around and they were just staring at you and they don't come and sit next to you. So, when you are talking about the broader systems, yes, there are those barriers there for Aboriginal people. (Urban Aboriginal patient)" (p4.)*	An Aboriginal reference group was formed prior to the study commencing 2 Indigenous authors on the project

(C. C. J. Shepherd et al., 2017)	To examine the effects of both direct and vicarious racial discrimination on a range of child health indicators.	Footprints in Time longitudinal survey, conducted annually	1239 Indigenous children aged 5-10 years. Wave 1: recruited at 6 months-2 years n=954; 3.5-5years n=717. Retention rate of 74% by wave 6.	National, recruiting from 11 sites across Australia	Questions: *"Have you been treated unfairly or discriminated against or been treated badly because you are Aboriginal/* *Torres Strait Islander?"* *"How often does your family experience racism, dis-crimination or prejudice?"* *"As far as you know, has the study child been bullied or treated unfairly at preschool/* *school because he/she is Aboriginal or Torres Strait Islander?"*	Institutional, systemic and interpersonal. Experiences and perceptions of racism as well as vicarious trauma associated with racism	"Two-fifths (40%) of primary carers, 45% of families and 14% of Indigenous children aged 5–10 years were reported to have experienced racial discrimination at some point in time. The majority (69%) of primary carers that had experienced racial discrimination had a time-limited exposure (reported in one wave only), while 31% experienced persistent racial discrimination (reported in multiple waves). A similar pattern was observed for family members (60% time-limited and 40% persistent) and study children (72% and 28%, respectively) (p5)"	1 SEWB measure 5 physical health measures "physical health indicators were primarily chosen on the basis of prior research on the relationship between racism and physical health among ethnic population groups" (p.3) "Primary carer and child experiences of racial discrimination were each associated with poor child mental health status (high risk of clinically significant emotional or behavioural difficulties), sleep difficulties, obesity and asthma [with the ORs ranging from about 1.7 to 2.7], but not with child general health or injury. Children exposed to persistent vicarious racial discrimination were more likely to have sleep difficulties and asthma in multivariate models than those with a time-limited exposure." (p1) Effects only slightly attenuated when other factors added to the analysis. This suggests that the socio-demographic circumstances of Indigenous families have little impact on the relationship between racism exposure and the health of children." (p.6) "We have shown that racism is associated with mental health and aspects of the physical health of Indigenous children in Australia, with the most consistent results relating to mental health status, sleep difficulties, obesity and asthma" (p.8).	Not stated
(Shepherd et al., 2018)	To identify predictors of distress and to test the protective impact of cultural engagement for Indigenous people in custody.	Qualitative – Secondary analysis of data from Koori Prisoner Mental Health and Cognitive Function Study (KPMHS). Questions were delivered F2F as an interview structure.	Aboriginal and Torres Strait Islander prisoners N=87. 75 male + 12 female.	Victoria 11 regional and metropolitan prisons.	The KPMH study questionnaire comprised 10 items referring to self-reported life stressors experienced in the 12 months prior to custody, including *"Were you treated badly because of your Indigenous heritage?"*	Interpersonal, structural	29.8% reported being treated badly because of their Indigenous heritage.	People incarcerated reported higher levels of distress on Kessler K5 Distress Scale: adjusted mean = 12.05 (SD = 5.05, range: 5–25). The mean adjusted distress score is above the K5 High/Very High distress threshold of 12 and in line with previous Indigenous custodial K5 scores. Being treated badly because of Indigenous heritage was one of 3 life stressors that correlated with psychological distress ($r=0.25$, $p<0.05$); correlation persisted even after controlling for family members/ close friends passing away and cultural engagement. Cultural engagement was found to predict lower levels of stress and a reduction in discrimination related stress.	Not stated but at least one Indigenous author listed Consultation with Aboriginal psychologists Interviews conducted by Aboriginal research officer
(S. M. Shepherd et al., 2017)	To explore the psychosocial stressors, stigma, and intersectional experiences of Aboriginal and Torres Strait Islander people who use meth-amphetamine, focusing on the role of racism and other systemic factors in influencing health outcomes.	Mixed-methods –Cross-sectional survey and qualitative interviews and focus groups.	Quantitative survey: n=734, with 59% identifying as Aboriginal and Torres Strait Islander (n = 433). Qualitative: N=147 community members and those with experience of methamphetamine use (80% Aboriginal or Torres Strait Islander) participated in 19 focus groups and 7 interviews.	10 sites in Australia, including remote, outer-regional, inner-regional, and urban settings.	Racism was measured as part of psychosocial stressors through survey questions, with participants reporting how often they experienced racism (options included "Never," "Sometimes," "Most times," and "All the time")	Systemic and personal racism, particularly in health care, policing, and community interactions. Participants also reported structural discrimination resulting from their Indigenous status.	34.1% of Aboriginal and Torres Strait Islander participants reported experiencing racism "most times" or "all the time," with over 90% experiencing racism "at least sometimes."	Racism and other psychosocial stressors, such as family separation and grief, contributed to high levels of psychological distress, lower mental health diagnoses, and difficulty accessing healthcare services. These stressors also compounded methamphetamine use and related harms.	The study involved Aboriginal and Torres Strait Islander participants, community members, and service providers with direct experience of methamphetamine use and its impact. Also, through focus groups and interviews. Qualitative data were analysed by two non-Indigenous members of the study team, with oversight by Aboriginal and Torres Strait Islander co-authors. Facilitators of focus groups and interviews not stated.

(Sivak et al., 2023)	To examine the mental health of former refugees living in regional Australia, focusing on their experiences of resettlement and the barriers to accessing mental health services.	Qualitative – 6 focus groups and 7 individual interviews.	31 participants (24 in focus groups, 7 in individual interviews) including adult and youth former refugees from Afghanistan, Bhutan, Burma, Sierra Leone, Sudan, and Iran, and essential service providers.	Launceston, Tasmania	Experiences of discrimination were recorded in the context of service provision, such as inconsistent availability of interpreters and cultural insensitivity in mental health services.
(Smith et al., 2019)	To explore the causal effect of Aboriginal Australian mothers' experience of perceived racism on their children's SEWB, with a focus on whether this effect is mediated by the mothers' parenting sense of competence.	Longitudinal cohort study using data from the South Australian Aboriginal Birth Cohort (SAABC), analysed through single causal mediation analysis.	159 Aboriginal mothers and their children (from a total baseline sample of 448 participants in the cohort). Data were collected during pregnancy (baseline) and at a five-year follow-up.	South Australia.	Perceived racism was measured using the Measure of Indigenous Racism Experiences (MIRE), which assessed experiences of interpersonal racism across multiple settings.
(Snyder et al., 2023)	To explore the everyday processes of *social sorting* experienced by Indigenous Australians living with disability under Australia's Disability Support Pension (DSP) system, and to analyse the impact of DSP reforms since 2015, particularly how Indigenous Australians are excluded from the system due to structural and procedural barriers	Qualitative research based on interviews with Indigenous Australians living with disabilities, their family members, and advocates.	Number not stated. However, the study includes Indigenous Australians living with disabilities in regional areas, their family members, and advocates	Regional towns in Australia	No specific instrument was used. Racism and discrimination are discussed in the context of systemic exclusion from the disability social security system, which disproportion-ately affects Indigenous Australians due to structural barriers, culturally inappropriate service delivery, and racialised assumptions about work ability.
(Soldatic & Fitts, 2020)	To examine the factors influencing Aboriginal Australian women's decisions to disclose intimate partner violence (IPV) during pregnancy, in the context of routine antenatal screening.	Qualitative – Semi-structured interviews	12 Aboriginal women, aged 20-36 years. Six disclosed the abuse, and six did not.	NSW. Five Aboriginal and Maternal Infant Health Services (2 urban, 3 regional) and one mainstream hospital.	Racism in the form of perceived risk/fear of statutory child protection services, which influenced decisions around disclosing IPV.
(Spangaro et al., 2016)	To explore the perceptions of COVID-19 vaccines among populations who have experienced discrimination in the Australian healthcare system.	Qualitative – drawing on data from four different studies. Semi-structured interviews.	The total number of participants was 119, across four groups: Aboriginal people (n = 36), People Who Inject Drugs (PWID) (n = 32), People Living with HIV in Australia (PLHIV) (n = 15), and Gay and Bisexual Men (GBM) (n = 26).	Various locations across NSW and Australia, including metropolitan and regional areas.	Experiences of discrimination were discussed based on historical and structural racism, particularly regarding mistrust of mainstream healthcare services among Aboriginal people, and stigmatisation of PWID, PLHIV, and GBM due to drug use, HIV status, and sexual orientation.
(Storer et al., 2023)	To explore the communication experiences of Aboriginal people with healthcare professionals regarding pain management, focusing on barriers.	Qualitative – focus groups	40 participants (20 men and 20 women). All participants were from two Aboriginal communities in SE QLD and reported health conditions associated with pain for which they sought healthcare.	QLD - 1x regional town and 1x rural Aboriginal community.	Not defined. Systemic racism and stereotyping in healthcare, discussed in terms of attitudes of healthcare providers towards Aboriginal patients, often dismissing or de-prioritising their pain.

Systemic discrimination – especially in relation to the inconsistent provision of interpreters and a lack of culturally sensitive and trauma-informed practices in healthcare settings.	Not explicitly quantified, but participants frequently reported facing challenges due to cultural misunderstandings and inconsistent or insufficient language support.	Discrimination and barriers to appropriate mental health services, such as language difficulties and a lack of trauma-informed care, exacerbated mental health issues among the refugees.	The study involved both former refugees, who shared their personal experiences through interviews and focus groups, as well as Essential Service Providers (ESPs), who represented specialised services accessed by the refugees. The research team triangulated data by including the perspectives of both ESPs and former refugees.
Perceived interpersonal racism, experienced by mothers in various social settings.	Nearly half (49%) of the Aboriginal mothers reported experiencing perceived racism in at least one setting during pregnancy.	Maternal experiences of perceived racism were linked to a 28% increase in the odds of children experiencing high social and emotional difficulties at the age of five. However, the effect was not mediated by the mothers' sense of parenting competence.	The study used Aboriginal research officers conducting data collection.
Systemic discrimination	Indigenous Australians are statistically underrepresented in DSP access, despite being up to 2.7 times more likely to live with chronic conditions or disabilities compared to non-Indigenous Australians.	Indigenous Australians' exclusion from DSP and lack of access to appropriate services contribute to worsened health outcomes and social disadvantage, exacerbating mental health distress due to the burdens of navigating the system.	Not stated.
Institutional racism—related to perceived risks of child removal by statutory services and a lack of culturally safe services.	Not quantified. However, institutional racism played a significant role in non-disclosure decisions for several women, especially due to fears of intervention by child protection services.	Non-disclosure of IPV, driven by fears of institutional control and racism, was linked to continued exposure to violence, exacerbating health risks for both mothers and their babies.	Aboriginal investigators and a trainee Aboriginal researcher were involved in the study, and the research was conducted with guidance from Aboriginal elders and community-controlled organisations.
Systemic and interpersonal discrimination within healthcare settings.	Not quantitatively measured. However, the study highlights widespread distrust in healthcare services among Aboriginal people and varying degrees of mistrust among other marginalised groups based on past experiences of discrimination.	Discrimination and mistrust in healthcare contributed to vaccine hesitancy, with Aboriginal participants expressing concerns about being "guinea pigs" for the vaccine. PWID also expressed concerns about the legitimacy of the vaccine, while PLHIV and GBM were generally more trusting of vaccination due to positive past experiences with biomedical technologies.	Only the Aboriginal participants were engaged through peer-led interviews, involving young Aboriginal interviewers.
Systemic and interpersonal discrimination and racism. Particularly experiences of being disregarded or treated with less urgency by healthcare providers, who were perceived to stereotype them.	Not quantifiably measured. However, study provided numerous qualitative accounts of negative experiences with healthcare professionals, including perceptions of disrespect and lack of care, communication breakdowns between patients and providers, negative attitudes of HCPs who often dismissed or de-prioritised their pain, being stereotyped as "drunks" or unworthy of equal care.	Reluctance to report pain due to negative past encounters with healthcare professionals led to inadequate pain management. Emotional pain related to historical trauma was often reported as more severe than physical pain, and participants frequently mentioned that their physical pain was overlooked.	The study involved Aboriginal researchers who facilitated the focus groups and guided the cultural sensitivity of the research process. Additionally, an Aboriginal community leader reviewed the findings to ensure they reflected the participants' views accurately.

(Strong et al., 2015)	To identify (1) levels of Social and Emotional Wellbeing (SEWB) and (2) the extent of unmet needs among cognitively impaired and non- cognitively impaired Aboriginal people in custody.	Quantitative – cross-sectional questionnaire to assess cognitive impairment, SEWB, and unmet custodial needs	122 adult Aboriginal and Torres Strait Islander prisoners (107 male and 15 female).	Victoria - regional and metropolitan prisons.	Racism was assessed through self-reported experiences of negative treatment due to Indigenous heritage.
(Sullivan et al., 2019)	To elucidate incarcerated Aboriginal women's experiences of prison healthcare, to investigate equity of access to culturally safe healthcare in prison, and to identify pathways for improving the accessibility of culturally safe healthcare.	Qualitative – 43 semi-structured interviews.	43 women in 6 prisons, a combination of minimum, medium, and maximum security prisons.	located in urban and regional locations in NSW	
Sullivan, Kendall et al. (2019)	To describe the social, emotional and physical wellbeing of Aboriginal mothers in prison, using a SEWB lens.	Quantitative – cross-sectional survey. Indigenous-informed decolonising research methodology	161 Aboriginal women who identified as mothers (77 in NSW + 84 in WA). 50% of mothers reported MH problems. Mothers in NSW reported poorer health and functioning, and more MH problems than in WA.	Prisons in NSW (n=6) and WA (n=5), including minimum, medium and maximum security correctional centres.	Racism not defined. Measures included Kessler 5 measure of psychological distress. Questions asked participants if they felt discriminated against.
(Temple et al., 2019)	To examine the prevalence and context of racism self-reported by older Aboriginal and Torres Strait Islander people.	Quantitative– structured interview conducted by Bureau of Statistics (ABS) between September 2014 and June 2015	2606 participants, completed a structured interviewed. Data for this study is from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS).	Australia-wide - remote and non-remote areas, including discrete communities,	Unfair and avoidable disparities in power, resources, capacities or opportunities centred on ethnic, racial, religious or cultural differences

Personal discrimination based on Indigenous status, focusing on how prisoners were treated because of their Indigenous background.	47.8% of cognitively impaired participants reported experiencing racism compared to 27.1% of those without cognitive impairment but result not significant.	Those who experienced racism reported worse mental health outcomes, with increased emotional difficulties and discomfort around non-Indigenous people, impacting their SEWB.	Aboriginal and Torres Strait Islander research officers and psychologists were involved in the study design, data collection, and/or participant engagement.
Systemic racism, stereotyping, and discrimination in accessing healthcare in prison.	Not quantifiably measured. The study provided numerous qualitative accounts of negative experiences with women trying to access healthcare with the prison system. They described that healthcare decisions were based on stereotype, rather than on their actual symptoms or requests, and they consequently were not able to access healthcare for the same health problems as non-Indigenous women. Being accused as being a 'drug-chaser' for seeking pain medication when she had not asked for it and not being provided with any treatment for health problem.	Led to a worsening of symptoms, compounded distress, and life-threatening health crises. Some women described becoming suicidal after requests for help were repeatedly ignored by custodial staff. Due to the loss of their patient rights to complaint and resolution, these women had no choice but to persevere with staff members who continually discredited the legitimacy of their requests	
Systemic and interpersonal discrimination.	Not reported.	Australian prison health surveys do not apply Aboriginal concepts of health and social and emotional wellbeing (SEWB). Experiences of discrimination was significantly associated with poorer mental health and increased psychological distress. The women's histories of forced removal under discriminatory child protection policies and the ongoing intergenerational trauma of separation from their own children due to incarceration adds to poor SEWB outcomes, especially psychological distress, anxiety, depression and overall MH. NB. The health and SEWB of Aboriginal mothers in prison as inextricably connected to the health and SEWB of their children, families and communities	Study applied an Aboriginal view of health and SEWB. Community consultation phases were undertaken in both states, led by senior female Aboriginal researchers, culminating in the formation of project advisory groups in each state to guide the research team on the data collection, analysis and dissemination strategy. The project advisory groups consisted of members from ACCHOs, Aboriginal community organisations, community experts, and Corrective Services and Justice Health.
Systemic and interpersonal discrimination	Unfair treatment (31%) and avoidance (15%) in last 12 months, oftentimes occurring in contexts critical to human capital investments. Those with higher levels of education were more likely to report experiences of unfair treatment. The prevalence of unfair treatment and avoidance remains relatively high in later life (albeit lower than younger ages), with a significant reduction from age 65. Compared to those aged15–29, the prevalence of self-reported racism is higher in mid-age (40%) and slightly lower for those 45 and over (31%). Although the prevalence is lower for the older age group, those who do experience unfair treatment are more likely to cite it occurring 'Always' or 'Often' (22%) compared to the younger age groups (approx.16% for both age groups).	Over one in three Aboriginal people reported an experience of unfair treatment in the 12 months prior to the survey. Exposure to racism in access to services can have direct deleterious effects on physical and mental health. It can also result in reduced help seeking or avoidance of services. For example, exposure to racism in health services has a greater impact on health than exposures in other settings. The study highlights the potential of racism to exacerbate the challenges of ageing and the importance of better understanding racism in the older population. It also shows that key impacts of racism vary throughout the life cycle and that older people may be bearing the costs of potential cumulative impacts of discrimination over the lifespan.	Not stated.

(Temple, Wong, et al., 2020)	To examine the prevalence and impacts of interpersonal racism and avoidance behaviours among Aboriginal and Torres Strait Islander individuals with disabilities, investigating how experiences of discrimination are related to disability type, severity, and avoidance in various settings.	Quantitative - cross-sectional survey design, analysing data from the 2014-2015 National Aboriginal and Torres Strait Islander Social Survey.	Aboriginal and Torres Strait Islander individuals aged 15–64 with and without disabilities, n=6,083 responded to questions regarding unfair treatment and discrimination.	Across Australia	Interpersonal racism was measured through 6 questions that asked if participants had experienced specific discriminatory actions, such as name-calling, being ignored, or being refused service, within the past 12 months due to their Aboriginal or Torres Strait Islander identity. Also which contexts discrimination occurred in.	Interpersonal racism, specifically experiences of unfair treatment and prejudice in various societal contexts, including work, education, healthcare, and public spaces.	42% of Aboriginal and Torres Strait Islander individuals with disabilities reported experiencing racism, compared to 32% among those without disabilities. Frequency and intensity of discrimination were higher among individuals with multiple or more severe disabilities, with odds of experiencing racism being 1.56 times higher for those with any disability.	Participants who experienced racism reported higher levels of avoidance of essential services, including healthcare and government services. Mental health impacts included stress and a reluctance to seek necessary care, further compounded by experiences of discrimination.	The study involved consultations with Aboriginal and Torres Strait Islander groups during survey development to ensure cultural sensitivity. Authors on the study are Indigenous Australians, including Indigenous Australians with lived experience with disability.
(Temple, Kelaher, & Paradies, 2020)	To analyse the association between racial discrimination and psychological distress among older Aboriginal and Torres Strait Islander people.	Quantitative - Analysis of NATSISS data -collected from personal interviews using a CATI questionnaire	2,606 Aboriginal and Torres Strait Islander people aged ≥ 45 years of age	National - Private dwellings in remote and non-remote areas, including discrete communities.	Unfair and avoidable disparities in power, resources, capacities, or opportunities centered on ethnic, racial, religious, or cultural differences	Systemic and interpersonal discrimination	Experiences of racism (as measured by unfair treatment) and avoidance are encountered by a significant minority of older Aboriginal and Torres Strait Islanders, with 31% reporting unfair treatment and 17% reporting engaging in avoidance behaviours	There is a clear association between experiences of racism and avoidance with psychological distress, with these results being robust to a range of confounding factors and complex survey design features. The associations between racism and distress are amplified by the severity of racism, and, when occurring, with avoidance.	Not stated.
(Thackrah et al., 2021)	To examine early career midwives' observations, experiences and responses to racism in maternity settings as part of a longitudinal investigation into the legacy of university initiatives to enhance midwives' cultural capabilities	Qualitative - semi-structured interviews including yarning.	14 non-Indigenous midwives and 2 Aboriginal midwives, aged between 20-40	WA and QLD. Perth metropolitan area, two in regional/rural areas (Bunbury and Katanning), and one in Brisbane.	Racism has been defined as "organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups"	Institutional racism	Not quantifiably measured. The study provided numerous qualitative accounts of negative experiences with women trying to access healthcare.	The findings indicate that racism—both casual and institutional—significantly influences health outcomes for Aboriginal women and their communities. Casual racism was observed in clinical settings, often manifesting as stereotyping and dismissive attitudes towards Aboriginal women, leading to negative experiences such as lack of support, mistrust, and poor communication. This treatment discourages Aboriginal women from engaging with healthcare services and contributes to feelings of isolation and alienation during childbirth.	Interviews with Indigenous participants were conducted and recorded by the Aboriginal coordinator and involved discussions (yarning) with Aboriginal community members
(Thurber et al., 2022)	To quantify the contribution of interpersonal discrimination to the overall prevalence of psychological distress among Aboriginal and Torres Strait Islander adults.	Quantitative - cross-sectional analysis of data from the longitudinal Mayi Kuwayu: the National Study of Aboriginal and Torres Strait Islander Wellbeing	9951 Aboriginal and Torres Strait Islander participants aged >18 years	Australia wide	No definition given. Everyday discrimination was measured using an 8-item measure modified from the Everyday Discrimination Scale.	Interpersonal discrimination	5430 (59·3%) of 9156 participants experienced any everyday discrimination (excluding missing data from 795 participants). 3712 (42·0%) of 9951 experienced everyday racial discrimination (excluding missing data from 1116 participants).	3588 (39·2%) of 9148 participants experienced high or very high psychological distress. Nearly half (49.3%) of the total burden of psychological distress among Aboriginal and Torres Strait Islander adults is potentially attributable to experiences of everyday discrimination, with 27.1% specifically linked to everyday racial discrimination. The study highlights that everyday racial discrimination explains up to 47.4% of the psychological distress gap between Indigenous and non-Indigenous adults. People experiencing poor mental health might be more likely to be vigilant and notice instances of discrimination, or to under-report experiences due to desensitisation. Previous experiences of discrimination and the threat of future discrimination can also lead individuals to be vigilant	Not stated

(Thurber, Colonna, et al., 2021)	To quantify experiences of everyday discrimination in a national sample of Aboriginal and Torres Strait Islander adults (≥16 years), overall and by key characteristics; to apply an outcome-wide approach to quantify the relationship between experiences of discrimination and wellbeing outcomes; and to test whether associations between experiences of discrimination and wellbeing outcomes vary by attribution of discrimination to Indigeneity	Quantitative - cross-sectional analysis of data from the longitudinal Mayi Kuwayu: the National Study of Aboriginal and Torres Strait Islander Wellbeing	9691 Aboriginal and Torres Strait Islander participants aged ≥16 years living in diverse settings across Australia. Baseline data collection commenced in 2018, and recruitment is ongoing. The current cross-sectional analysis is based on Mayi Kuwayu Study Release 2.0	Australia wide	Racism is an organised social system that operates on multiple levels to reinforce, justify, and perpetuate a racial or ethnic hierarchy that devalues, disempowers, and differentially allocates resources to groups defined as "inferior" or "superior" Everyday discrimination measured using an 8-item measure modified from the Everyday Discrimination Scale. Categorised as "not at all" (coded as 0), "a little bit" (1), "a fair bit" (2), "a lot" (3). Total score categorised as no (score 0/24), low (1–8/24), or moderate to high (9–24/24) discrimination.	Structural and interpersonal	41.5% reported no discrimination, 47.5% low, and 11.0% moderate-high. Discrimination was more commonly reported by younger versus older participants, females versus males, and those living in remote versus urban or regional areas. Experiences of discrimination were associated with indicators of reduced cultural wellbeing: low control over life, feeling torn between Aboriginal and Torres Strait Islander and non-Indigenous culture, and feeling disconnected from Aboriginal and/or Torres Strait Islander culture	Discrimination experiences were strongly associated with SEWB outcomes in this study. It was three to four times as common for those experiencing moderate-high, compared to no discrimination to report low life satisfaction and low happiness. The strength of the association varied across outcomes, from a 10–20% increased prevalence for some outcomes (e.g. disconnection from culture (PR = 1.08; 95% CI: 1.03, 1.14), and high blood pressure (1.20; 1.09, 1.32)), to a five-fold prevalence of alcohol dependence (4.96; 3.64, 6.76), for those with moderate-high versus no discrimination exposure	The study involved Aboriginal researchers who facilitated the focus groups and guided the cultural sensitivity of the research process. Additionally, an Aboriginal community leader reviewed the findings to ensure they reflected the participants' views accurately.
(Thurber, Walker, et al., 2021)	To validate instruments developed to measure interpersonal discrimination	Instrument testing and validation for the Mayi Kuwayu Study. Discussion with experts and 5 focus groups and field test with baseline survey.	7501 participants in baseline survey	National	Racism is a system of oppression based on the social ranking of groups of people into categories of race, with those lower in the social strata considered inferior and denied access to rights, resources, and opportunities. The 8-item instrument captures experiences of discrimination in everyday life. The instruments do not use objective measures of frequency (i.e. weekly or daily), as previous research has demonstrated that subjective assessment of frequency can be easier than quantification.	Structural and interpersonal	Half (55.4%) of participants reported experiencing any everyday discrimination, with 65.7% attributing the discrimination to Indigeneity.	34.1% reported experiencing everyday discrimination in healthcare, with 51.1% attributing the discrimination to Indigeneity. The study assessed the association between discrimination scales (everyday discrimination and healthcare discrimination) and experiences of community-level racism. The results indicated a significant association between higher reported discrimination and increased problems related to racism in the community and the correlation between discrimination scales and psychological distress	Not stated
(Twizeye-mariya et al., 2017)	To estimate the prevalence of childhood risks for poor mental health in Indigenous Australian children, noting that Indigenous Australians by virtue of their history of traumatic colonization and dispossession, child removal, and racism are potentially at greater risk.	Quantitative – using Longitudinal Study of Indigenous Children (LSIC) data	A cohort of 1,671 children followed up on 6 occasions, resulting in 8,378 person-observations.	National	Racism defined by family (usually mother) with the question: *How often does your family experience racism, discrimination, or prejudice?* Scored on 5-point scale: [1] Every day, [2] Every week, [3] Sometimes, [4] Only occasionally, or [5] Never or hardly ever. Question on bullying: *Do the children at (preschool/ school) pick on you?* Scored as yes/no and on 6-point scale from [1] Yes, always to [6] No, never	Interpersonal	1 in 5 children experienced racism, discrimination or prejudice in any year and by 29% over the 8 years of data collection. Being bullied was reported by 36% of 8- to 10-year-old children and 41% of 6- to 7-year-olds, with 69% reporting having been bullied at some time between ages 6 and 10.	More than 43% of Indigenous Australian children aged 6-10 years have 6 or more risk factors for mental illness, and 23% are experiencing current psychological distress. By age 8, only 4% of Indigenous children in LSIC had only 1 adverse experience and 46% of children aged 8-10 years had 6 or more risk factors for mental illness. Psychological distress, conduct problems and hyperactivity were most prevalent for those with 6+ risk factors. Indigenous children in LSIC are exposed to considerably higher rates of adversity than a general Australian sample from the Longitudinal Study of Australian Children (LSAC). The majority of children (> 67%) were exposed to 3 or more major life events in their family (eg, incarceration, death of family member, lost job) in any one year, with 95% ever exposed, vs 14% of children in LSAC. Few children (< 2%) were exposed to low parental warmth and, despite the high exposure to adversities, less than 5% of children report low self-confidence, indicating resilience. Many Indigenous Australian children, from infancy, are at significant risk of developing mental illness based on the high prevalence of accumulated childhood stressors.	LSIC Steering Committee has been chaired by an Indigenous leader, Professor Mick Dodson AM, since 2003, and includes a majority of Indigenous members. Consultation and negotiation have been integral to the research methodology in ensuring the genuine participation of Indigenous people and a sense of local ownership. LSIC held extensive consultations with Indigenous communities in urban, regional, and remote areas to inform the development of the study design and content. The research questions guiding the LSIC study were thus framed within Indigenous contexts, and the data items and survey instrument items were selected for their relevance to Indigenous Australians.

(Valibhoy et al., 2017)	To determine the barriers young people from refugee backgrounds face accessing mental health services	Qualitative – in person interviews	16 young people (aged 18–25 years) born in 9 different countries who had ever received MH services.	Australia	Racism mentioned once only but not discussed thereafter.	Discussion pertains to barriers based on practitioners' cultural sensitivity	Mentioned once by authors in passing.	Barriers to access based on cultural insensitivity led to under-utilisation of mental health services. "Participants wanted practitioners to be ready to learn about and accommodate nuances in ethnic and religious identities… Overall, practitioners' level of cultural sensitivity contributed to participants' broader sense of feeling understood or misunderstood."	Participants only.
(Waterworth et al., 2016)	To explore Indigenous participants' perspectives of the factors that affect the health behavior of their community members	Qualitative – focus groups, with participatory action research method	120 members of two urban West Australian Indigenous communities	West Australia	As disclosed by participants	Historical, colonisation, including loss of culture	Historical and pervasive	Effects of historical racism affected the physical and psychological health of community members.	Positionality of author not stated (implied non-Indigenous). "Once support and advice were obtained, an advisory committee was convened within each community. These committees comprised elders and respected community members who provided advice and guidance throughout the study. They were actively involved in discussions concerning how to conduct the research and interpret the data, and conducting the focus groups. Two members of each community were employed to assist with the research."
(Waterworth et al., 2015)	To gain an understanding of participants' views on the factors influencing health behaviour within Indigenous groups in Western Australia	Qualitative – in depth interviews	29 people who support Indigenous people; 13 Indigenous, 16 not Indigenous, age 29-	West Australia	As disclosed by participants	Systemic	Constant	Racism in conjunction with other factors interact to affect health behaviour in a complex manner. "Distrust created by historical and contemporary racism may impede any health and broader assistance that might be gained from non-Indigenous sources. Conversely, it also highlights the conundrum involved in promoting health behaviour without reinforcing oppression or inequalities. It also points to the necessity for Indigenous community coalition driven efforts to improve health behaviour as a way of reducing inequities and empowering communities"	Nil from authors, Research advisory committee included two Indigenous community members.
(Worrall-Carter et al., 2016)	To explore Aboriginal patients' lived experiences of cardiac care at a major metropolitan hospital	Qualitative study involving in-depth interviews	10 Aboriginal patients who had been treated in the cardiology unit	Melbourne, Victoria	As disclosed by participants	Interpersonal.	2/10 participants reported racist experiences: Ignored by staff, perceived due to Aboriginality; unprofessional comments	Not directly stated	Aboriginal researcher on study team
(Yeasmeen et al., 2023)	To investigate different types of racism experienced by Muslim and non-Muslim women	Quantitative - Survey	580 culturally and linguistically diverse (CALD) Victorian women from four local areas including both rural and urban communities.	Victoria	Variables in model - Verbal Abuse; Exclusion; Treated Improperly; Vandalism and Physical Threats	Interpersonal	Muslim women, in general, had higher odds of experiencing Racism including being sworn at or verbally abused or exposed to offensive gestures, and being told that they do not belong in Australia and should go back to their country	Muslim women were more likely to be above the threshold for high or very high psychological distress than non-Muslim women, consistent across most types of racism.	Positionality of author not stated but implied.
(Ziaian et al., 2023)	To investigate how experiences of discrimination, in combination with relationships within families, impacted psychological wellbeing of refugee-background Youth.	Quantitative - survey	556 youth from refugee backgrounds, aged between 14-26 and studying at school, vocational or tertiary institution. Born in South Asia (n=139), Middle East (n=215) or Africa (n=202).	South Australia	The Perceived Discrimination Scale, adapted from the MIRIPS study, a 5-item scale rated from 1 (strongly disagree) to 5 (strongly agree). It assessed perceptions of being treated unfairly, threatened, or feeling unaccepted because of one's ethnicity. Higher scores indicate more perceived discrimination.	Perceived discrimination e.g. 'I feel Australians have something against me'	Extent of discrimination not reported.	Discrimination played a significant role in the lives of youth from refugee backgrounds, particularly in relation to psychological distress and integration, even in the presence of family support. Discrimination had a direct effect on psychological distress (β =.025, p= .001,) not moderated by resilience or family integration.	Not stated.

(Ziersch et al., 2020)	To report responses to discrimination by refugees and asylum seekers, and how these responses influence the impact of discrimination on health	(i) Survey; (ii) Semi-structured Interview	(i) Adult refugees and asylum seekers (n=423) (ii) 65	South Australia	A single item discrimination measure from the Scanlon Foundation was used: *'Have you experienced discrimination or been treated unfairly in Australia because of your skin colour, ethnic origin or religion?':* yes, more than 12 months ago; yes in last 12 months or no. Also settings.
(Ziersch et al., 2021)	To examine (a) What are the experiences of work, exploitation, and discrimination for temporary visa holders? (b) Do temporary visa holders take action in relation to experiences of exploitation or discrimination? and (c) What is the health impact of these experiences?	Semi-structured interview	30 holders of non-refugee temporary visas (n=11) or refugee temporary visas (n=19).	South Australia	As disclosed by participants

Interpersonal and systemic. Perceptions of discrimination - general	22% of survey participants reported experiences of discrimination since arriving in Australia (14% in the last year), including incivility, physical assault, and denial of services. Experiences varied by length of time in Australia, continent of birth, religion and visa status. 31 of the 65 interview participants described personal experiences of discrimination in Australia, and 7 more gave accounts of others (friends, relatives, community members) who had.	Survey data indicated that 90% of those who reported experiences of discrimination (n=91) felt that discrimination had harmed their health. Those who reported discrimination had significantly worse mental health ($p < .001$) but not physical health. In interviews, participants reported affective, cognitive and behavioural responses to these experiences of discrimination, all with potential impacts on health e.g. stress, sadness, fear, shame and hopelessness.	Not stated. Interviews were conducted by 4 female researchers, none of whom were migrants. There was also evidence of some reluctance to discuss and name discrimination with interviewers – authors suggested this was so as not to appear 'ungrateful' or to 'upset' interviewers but also out of fear of potential impacts on visa determination.
Experiences of exploitation and discrimination in the Australian labor market that included difficulties securing work, underpayment, overwork, and hazardous workplaces.	Seven of the 11 participants on non-refugee temporary visas and 16 of the 19 participants on temporary refugee or bridging visas reported experiencing some form of exploitation or discrimination in the Australian labour market	These experiences had negative health effects, particularly on mental health	Not stated

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Appendix 2: Scope of Work

National Anti-Racism Framework Project

Scoping research on the impact of racism on health outcomes for Aboriginal and Torres Strait Islander Peoples and people who are racially and culturally marginalised.

Background:

In March 2021, in response to long-standing calls for action against systemic racism in Australia, the Australian Human Rights Commission (the Commission) called for the development of a National Anti-Racism Framework (NARF) as a central refence point to guide a whole-of-society approach to anti-racism.

Between May 2021 and April 2022, approximately 100 scoping level consultations were undertaken with 300 organisations. The Commission partnered with some of those organisations and agencies and had the privilege of facilitating 10 community consultations across the nation. The Commission also invited public submissions from October 2021 through February 2022 and received 164 submissions from a range of stakeholders including Members of Parliament, government departments, community organisations, and community members.

At the priority-setting level of the initial scoping phase, the Commission identified from consultations and submissions several key considerations for the principles that should underpin a framework, three cross-cutting themes, and three-sector specific priority areas, as well as various anti-racism strategies and solutions that a NARF should include.

There was strong support from submissions and consultation participants across the board for a NARF as an overarching and coherent approach to anti-racism. Consultation participants emphasised the need to cultivate broad-based racial literacy, an understanding of how race and racism operate within Australia, and knowledge of Australia's settler colonial and migration history and the ongoing impacts of discriminatory policies.

Submissions from Members of Parliament, government departments and community organisations identified the impacts of racism on poorer physical and mental health, social connection, wellbeing, and access to safe services. Submissions identified improved data collection practices, investment in cultural safety training and research to better understand racism's impact on health and healthcare access, and stable and ongoing funding for community organisations.

The initial scoping findings and preliminary recommendations provide a solid grounding for the projects continued work to develop and implement a NARF with the support of Federal Government provided to the Commission over the next four years.

The requirements:

The Commission wants to enhance its understanding of available evidence on data collection practices within health systems, the impact of racism on health outcomes and the role race and/or experience of racism plays in access to healthcare services for Aboriginal and Torres Strait Islander Peoples and people from culturally and linguistically diverse backgrounds. At the commission, we use the term people who are culturally and racially marginalised or people from other negatively racialised communities. This research will

contribute to the ongoing evidence, advocacy, and/or public education and awareness- raising efforts, both through a National Anti-Racism Framework and beyond.

The Commission is seeking a supplier to:

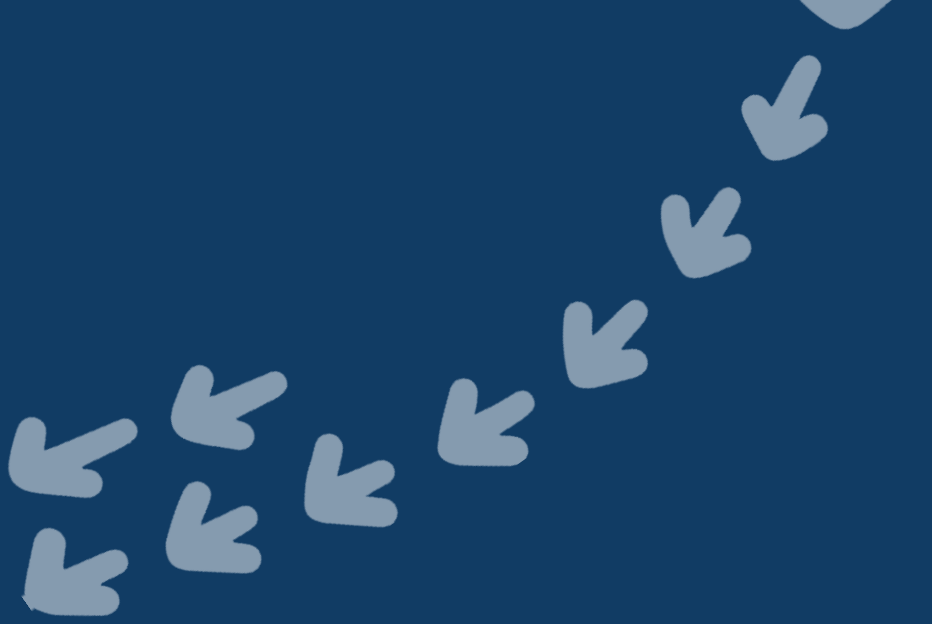
- Identify and summarise existing research on data collection practices in health systems including:
  - Demographic data collection practices that capture culture, ethnicity, migration and/or racial background.
  - Data collection practices around patients reporting experiences of racism within health services.
- Identify and provide a high-level summary of the health outcomes for Aboriginal and Torres Strait Islander People and people from culturally and linguistically diverse backgrounds.
- Identify existing qualitative research that explores the role of race and/or experiences of racism plays in accessing health services for Aboriginal and Torres Strait Islander Peoples and people from culturally and linguistically diverse backgrounds.
- Identify existing research, advocacy, and/or public education and awareness-raising efforts to tackle racism within healthcare systems through a systemic and intersectional lens.
- Identify the role of and/or opportunities for the Commission to contribute to ongoing research, advocacy, policy and/or public education and awareness-raising efforts around experiences of racism within the provision of healthcare.

The scope of the research can be refined by the supplier in consultation with the Commission, but it should include topics related to:

- Current data collection practices in relation to demographic data and experiences of racism
- High level summary of the history of disparate health outcomes among Aboriginal and Torres Strait Islander People
- High level summary of the health outcomes among culturally and linguistically diverse people (distinguishing between Australian born and recent migrants from non-English speaking backgrounds)
- Experiences of accessing healthcare for Aboriginal and Torres Strait Islander Peoples including experiences of racism, systemic barriers to access, and access to culturally safe and appropriate healthcare services
- Experiences of accessing healthcare for culturally and linguistically diverse people (distinguishing between Australian born and recent migrants) including experiences of racism, systemic barriers to access, and access to culturally safe and appropriate healthcare.
- The role of cultural safety and/or anti-racism efforts to provide culturally safe and inclusive healthcare services, and any best practice examples.
- Considering the role cultural communities play in the distribution and uptake of health information, such as experiences of culturally diverse communities during the COVID-19 pandemic.

The provision of these services will involve:

- Desktop research to identify existing research, advocacy, and/or cultural safety or anti-racism efforts within the scope stated above.
- Summarising relevant research findings.
- Identifying opportunities for the Commission to contribute to existing research, advocacy, and/or policy frameworks to support the provision of culturally safe and appropriate healthcare services.
- Production of a report that outlines the above, with key recommendations. We would like to be able to share this report publicly to support the forthcoming National Anti-Racism Framework.



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