



Racism, racial discrimination and child and youth health:

—— a rapid evidence synthesis ——



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FOR THEIR INPUT REGARDING QUANTITATIVE DATA.

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Executive summary

This report is a rapid evidence synthesis on racism and child and youth health commissioned by VicHealth to inform policy, practice and research. Racism and racial discrimination are fundamental causes and determinants of health and health inequalities globally. Children and young people are particularly vulnerable to racism's harms. Intergroup attitudes, beliefs and behaviours are also established in childhood, making this a priority time for action.

Understanding race and racism

Racism is an organised system of oppression that classifies and ranks social groups into 'races' and devalues, disempowers and differentially allocates power and resources to those considered inferior. Race has no biological basis and is not a biological reality. Yet race is a powerful predictor of which groups have access to opportunities and resources in society and which groups face barriers.

Racism is frequently conceptualised across 3 distinct, but interrelated, levels:

- a) **Systemic or structural racism:** structural racism is "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems". Institutional racism "refers specifically to racially adverse "discriminatory policies and practices carried out...[within and between individual] institutions" on the basis of racialised group membership."
- b) **Interpersonal racism:** discrimination between people, with varying degrees of frequency and intensity, including racially-motivated assault to verbal abuse, ostracism and exclusion.
- c) **Internalised (or intrapersonal) racism:** attitudes, beliefs, or ideologies often founded on understandings of supposedly innate superiority/inferiority, that may be held either by members of dominant social groups and/or by subordinate ones.

Pathways by which racism impacts child and youth health

Racism harms child and youth health through direct exposure to racism and pathways of stressor exposure as well as through the structural and societal legacies of historical and contemporary racism on communities, families and carers and their access to resources.

1) Racism leads to differential access to socioeconomic resources and to a broad range of societal resources and opportunities needed for health. Systemic racism within healthcare, education, housing, employment, the media and online, and in policing and criminal justice systems are key mechanisms by which racism can influence socioeconomic inequalities.

2) Racism can increase exposure to, and exacerbate negative effects of, other risk factors for health. Racism initiates and sustains some types of stressors such as discrimination and historical trauma but it can also affect the levels, clustering and impact of stressors such as unemployment, financial stress, neighbourhood violence or physical/chemical exposures in residential and work environments.

3) Behavioural, physiological and psychological responses to racism, as well as individual and collective resilience, are also important mechanisms shaping health outcomes. For example, reduced healthy behaviours (e.g. exercise, diet, sleep) and/or increased unhealthy behaviours (e.g. substance misuse) either directly as stress-coping or indirectly via reduced emotional-regulation. Racism and exposure to associated stressors can also disrupt physiological regulatory systems and directly impact biological processes such as blood pressure, inflammation, hormonal levels and even cellular ageing.

Self-reported racial discrimination among children and young people

Self-reported experiences of racial discrimination are only one indicator of the wider system of racism. This report focuses on Australian data collected in the last 5 years (2016-2020). Data underscores the high prevalence of racial discrimination experienced by children and young people from Aboriginal and Torres Strait Islander backgrounds, and from some ethnic minoritised groups. However, substantial data gaps remain. Existing data is under-utilised, with investment in analysis of data already collected needed. There is also a need for large scale longitudinal data and for data collection beyond self-reported racial discrimination.

Evidence for addressing racism and racial discrimination

High quality evidence of effective anti-racism strategies among children and young people is relatively sparse, although promising approaches and key principles for action are identified.

- Racism must be named and addressed explicitly at a systemic, institutional level – too often interventions focus on addressing disadvantage and not on the racism that creates, maintains and justifies that disadvantage.
- Anti-racism efforts must foreground Aboriginal and Torres Strait Islander sovereignty and leadership. Community cultural groups need to be actively involved as architects and leaders in efforts that impact their communities. Ensuring children and young people are actively involved in co-designing anti-racism efforts is also critical.
- Anti-racism initiatives need to be life-course appropriate. That is, founded on developmental theories and current evidence regarding the development of prejudice and intergroup attitudes throughout childhood and adolescence. Not doing so increases potential for doing harm including reinforcing stereotypes and causing distress.
- Programs must undergo high quality effectiveness evaluations to ensure they do no harm.

Anti-racism at a structural and institutional level:

- initiatives to improve racial literacy among staff, as well as families and communities, regarding race, racism and health together with developmental theories and evidence – and to build commitment to anti-racism including in healthcare, education, the media, online and in community settings
- improved reporting and monitoring of racism and racialised inequalities including in healthcare, education, the media, online and in community settings
- organisational audits with accountability for inaction, explicit policies addressing racism, senior leadership commitment and communication regarding anti-racism as a priority, First Nations and ethnic minoritised peoples in leadership across key settings
- ensuring high quality Indigeneity and ethnicity data collection across settings
- legal and policy reform, including action on the Uluru statement recommendations and equal opportunity and human rights mechanisms.

Anti-racism at inter- and intra-personal levels:

- A combination of intergroup contact and training in empathy and perspective taking is most effective, this can include programs delivered in person and online.
- Multi-level, multi-strategy programs that target structural, systemic and institutional change not only individual-level attitudes and beliefs, and that are grounded in developmental and theory and evidence, are most effective.
- Effective programs require active involvement of a trained facilitator. Provision of materials or unstructured discussions alone are ineffective, and are likely to do harm.

The evidence outlined in this report will enable a more detailed understanding of the response required by VicHealth and its stakeholders to address racism as a fundamental cause of health and health inequalities for children and young people.

Background and introduction

Racism and racial discrimination are fundamental causes and determinants of health and health inequalities globally.^{1,2} Children and young people are particularly vulnerable to racism's harms.^{3,4} Racism is an organised system of oppression that classifies and ranks social groups into 'races' and devalues, disempowers and differentially allocates power and resources to those considered inferior.^{5,6} Race has no biological basis and is not a biological reality. Yet the concept of race remains a powerful social category in society today, and existing categorisations and perceptions of race have major social consequences.⁷ Race is a powerful predictor of which groups have access to goods and resources in society and which groups encounter barriers.⁸ Race and racism need to be explicitly named and addressed,⁹ with racism the mechanism by which racial categorisations have biological consequences.⁵

Racism is an ideology of power that advantages those considered superior and disadvantages those considered inferior.^{5,6} Racial discrimination is the behavioural expression of racism by actions at individual or institutional levels.¹⁰ Racism and racial discrimination have profound impacts on the lives of children and young peoples, their families and communities, shaping risks and opportunities and creating unjust, unnecessary and preventable differences in health between social groups throughout the life-course and across generations.^{11,12}

Racism, as a form of injustice, is, by definition, wrong.^{12,13} Studying how racism harms health, and identifying effective ways to address racism and its harmful health effects, is not to prove racism is wrong or unjust. Rather, we do so to further understanding of how racism shapes population health, to build evidence for accountability, to challenge unjust and unfair systems and structures, and to advocate for human rights and health equity.¹²

The coronavirus pandemic together with the concurrent resurgence of the Black Lives Matter movement and attention to the public health emergency of racism in Australia and around the world have further reinforced the need to address racism as a form of injustice and as a fundamental cause of health and health inequalities. There is now heightened attention globally and locally to the enduring social and structural injustices that are derived from racism as a system of oppression and the critical need for urgent action to address them.¹⁴

In Australia, Aboriginal and Torres Strait Islander peoples experience profound structural, systemic and institutional racism, which uniquely and actively manifests in ways including dispossession of land, child removal policies and disproportionately high incarceration rates. These are expressions of the deep injustices of ongoing colonisation that persist today.

Ethnic minoritised and migrant communities, not to be confused or conflated with Aboriginal and Torres Strait Islander peoples, experience systemic racism related to historical and contemporary migration and settlement experiences and legacies of legislation such as the White Australia policy.

"Structural racism involves interconnected institutions, whose linkages are historically rooted and culturally reinforced. It refers to the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values and distribution of resources, which together affect the risk of adverse health outcomes."¹⁵

Racial discrimination is a common stressor in the lives of many children and young peoples, with growing empirical evidence of negative associations between racial discrimination and multiple child and youth health outcomes.^{4,16-18} Longitudinal studies have documented effects of racial discrimination on mental health,^{19,20} substance use,²¹ and cortisol dysregulation,²² allostatic load²³ epigenetic ageing²⁴ and inflammation²⁵ among youth. Evidence also documents that impacts of racial discrimination are not limited to experiences where children and young peoples are direct targets of racism. Vicarious experiences of racial discrimination, including witnessing or hearing about others experiences, including online, are also associated with child and youth health outcomes including negative and positive dimensions of mental health and sleep duration, latency and quality.^{26,27} Concern about increasing societal discrimination is also associated with adolescent behavioural outcomes and depression.²⁸

Notwithstanding the need to address racism and racial discrimination due to their inherent injustice and unfairness, empirical studies reinforce the need for wide-ranging action and population-level interventions to promote societal anti-racism and bystander anti-racism action - and to ensure those who experience racism and racial discrimination and the associated health impacts of such experiences, receive appropriate support and services. In order to optimise wellbeing for all children, young peoples and their adult caregivers, and to achieve health equity for all, eradicating racism and both direct and vicarious racial discrimination from the lives of children and young peoples is an urgent priority.²⁹

Addressing racism is a priority in national policies including the National Aboriginal and Torres Strait Islander Health Plan 2013-2023³⁰ that identifies addressing racism as a social determinant of health and Australia's multicultural statement³¹ that identify racism and discrimination as key barriers to social cohesion. At a state level, the Victorian Aboriginal Affairs Framework 2018-2023³² identifies addressing racism and promoting cultural safety as key priorities and enablers of self-determination. Elimination of racism is explicitly identified as a goal, with addressing systemic and everyday racism in health, community services, education and learning, justice and other environments explicitly identified as areas for action. The Victorian Aboriginal and Local Government Action Plan³³ provides a practical framework to help councils engage with Aboriginal communities and promote reconciliation. Engagement of Aboriginal people in planning, decision-making, employment, programs and services is identified as a foundational practice for councils. This includes working with Aboriginal people to respond to and address racism. Balit Murrup: Aboriginal social and emotional wellbeing framework³⁴ which aims to support Victorian Aboriginal people, families and communities social and emotional wellbeing and mental health also explicitly identified racism as a key social determinant of health requiring attention, including for children and young people. The Productivity Commission's recently released Indigenous Evaluation Strategy provides a framework agencies to use when selecting, planning, conducting and using evaluations of policies and programs affecting Aboriginal and Torres Strait Islander people.³⁵ This framework puts Aboriginal and Torres Strait Islander people at its centre and recognises that the perspectives, priorities and knowledges of Aboriginal and Torres Strait Islander people must be central if outcomes are to be improved.

This rapid synthesis review comprises 3 main sections. First, an overview of race and racism, pathways and mechanisms by which racism and racial discrimination influence child and youth health, and a narrative review of current empirical findings is provided. Second, an key data collected in the last 5 years (2016-2020) on the prevalence of self-reported racial discrimination among 5-25 year olds in Victoria and Australia is presented. Third, evidence for addressing racism and racial discrimination among 5-25 year olds is reviewed.

Race, racism and child and youth health

Understanding race and racism

Racism is an organised system of oppression that classifies and ranks social groups into ‘races’ and devalues, disempowers and differentially allocates power and resources to those considered inferior.^{5,6} The very construction of “race” categorisations has historically reflected oppression, exploitation and social inequality.⁷ These categories have widely been incorrectly viewed as important markers of biological and genetic differences³⁶ with such views still common today. Race has no biological basis and is not a biological reality. Genomics and genetic research have clearly shown that most genetic variation is present among individuals and not among population groups and that human genetic variation does not naturally fall into subgroups that match racial categories. At a population-level, variations in biological characteristics do not inherently map onto “race” categories, and “ancestry” offers little about whether an individual has specific genetic traits.³⁷⁻³⁹ There are no ‘immutable, biologically based differences between “racial” groups’.⁸

That race is not real biologically has led to some arguing that race isn’t real altogether. This includes arguing that we should not talk about race or racism, and that collecting data about race and racism should be avoided.^{8,40} However, the concept of race remains a powerful social category in society today, and existing categorisations and perceptions of race have major social consequences.⁷ Race is a powerful predictor of which groups have access to goods and resources in society and which groups encounter barriers.⁸

The pervasive nature of race as a social construct is shown in the substantial health inequalities experienced by Aboriginal and Torres Strait Islander people⁴⁰ and by some other racialised and minoritised ethnic groups. Not talking about race or stating that race is not real does not make race less powerful, or make racism any less of a lived reality.^{40,41} Rather it minimises the trauma of racism and leads to indifference to inequalities that are very real.⁴⁰

Aboriginal and Torres Strait Islander scholars have strongly cautioned against focusing on ‘culture’ instead of ‘race’ as a way of avoiding the biological determinism of race.^{9,40} Such a focus on ‘culture’ prevents understandings of the ways in which race and racism lead to Aboriginal and Torres Strait Islander health inequalities and instead places responsibility with cultural misunderstandings or miscommunications and/or Aboriginal and Torres Strait Islander patients and culture.^{9,40} While Aboriginal and Torres Strait Islander people are not a ‘race’, ‘Aboriginal and Torres Strait Islander status’ is a highly meaningful racial category.⁴⁰

Scholars in migrant and ethnic minority health have also identified a focus on culture and cultural explanations as problematic and detracting from a focus on race and racism as core explanations for health inequalities.⁴²

Race and racism need to be explicitly named and addressed,⁹ with racism the mechanism by which racial categorisations have biological consequences.⁵ Naming racism explicitly in research, policy and practice is required to make sure race – or culture – is not seen as a risk factor, when racism – not race – is the cause of inequalities.⁴³

Like other systems of oppression, racism is frequently conceptualised across 3 distinct, but interrelated, levels:^{44,45}

- a) **Systemic or structural racism:** production, control and access to material, informational and symbolic resources within societal institutions, laws, policies and practices. While many use structural racism and institutional racism interchangeably, terms are considered two separate concepts.¹⁵

Structural racism is “the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems...(e.g., in housing, education, employment, earnings, benefits, credit, media [including social media and online], health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values and distribution of resources”, reflected in history, culture and interconnected institutions.^{15,46} Within this definition, institutional racism “refers specifically to racially adverse “discriminatory policies and practices carried out...[within and between individual] state or non-state institutions” on the basis of racialised group membership.”^{15,46}

- b) **Interpersonal racism:** discrimination between people, with varying degrees of frequency and intensity, including manifestations from racially-motivated assault to verbal abuse, ostracism and exclusion in person and online; and
- c) **Internalised (or intrapersonal) racism:** attitudes, beliefs, or ideologies often founded on understandings of supposedly innate superiority/inferiority, that may be held either by members of dominant social groups and/or by subordinate ones.

Racism is commonly expressed as prejudice (negative attitudes) and stereotypes (categorical beliefs) groups and discrimination (unequal treatment) of racialised and minoritised groups by individuals and within institutions. Not all dimensions of racism always co-occur, although they are often mutually reinforcing across levels.⁴⁷ Racism endures in systems, institutions and policies of society, even if explicit racial prejudice may not be present among individuals.⁴⁷ Systemic and structural discrimination is so entrenched it is seen as largely independent of individual-level discrimination.^{5,48,49} Feagin^{50,51} extends this further, considering a critical element of systemic racism to be a dominant white racial frame – that is, a dominant framing of society that ensures white privilege and dominance. For example, while individuals may not explicitly endorse negative racial attitudes and beliefs, neither do they see a need for change in existing systems and structures that continue to advantage whites. Racism and power cannot be understood independently of each other,⁵² though individual racial attitudes are fundamental in structuring a racialised social order and racial inequality.⁵³⁻⁵⁵ Racism is commonly viewed as based in ignorant, prejudicial or outdated ideas that simply require education. However, racism, including the social construction of race, is primarily a political project, focused on power and maintaining and reproducing the status quo.⁹

In discussing race and racism it is important to recognise that part of the construction of race is the homogenising and essentialising of different groups. That is considering all members of groups to be the same, as possessing the same essential characteristics.⁵⁶ This leads to narrow, stereotypical understandings of what it means to be an Aboriginal person, or what it means to be from an ethnic minority, and of what culture might mean to them.⁵⁶ Instead, Aboriginal and Torres Strait Islander people are diverse people with diverse histories, Aboriginal and Torres Strait Islander Australia is made up of many different and distinct groups, each with their own culture, customs, languages and laws.⁵⁷ As a result of colonisation, forced removal from land, forced removal of children, and other historical and contemporary policies of marginalisation and oppression, many Aboriginal and Torres Strait Islander do not live on their own country. In Victoria, as throughout Australia, it is important to recognise the wide diversity of Aboriginal and Torres Strait peoples and that many Aboriginal and Torres Strait peoples living in Victoria also have country and cultural ties elsewhere that shape their identities, experiences and health and wellbeing.

Giving substantive attention to race and racism, including documenting and addressing patterns of health inequality in relation to race as a social identity and racism as a fundamental cause, it is also important to consider multiple social identities. As recognised by the theory of intersectionality, different aspects of social identity, such as gender, sexuality, socioeconomic position, ability/disability, migration status, religion, geography, age, all interact with race.⁵⁸ Systems and processes of oppression and domination such as racism, classism, sexism, also interact at micro and macro levels. Varied interrelationships between social identities and interactions between social processes all can contribute to health and health inequalities.⁵⁸ Intersectionality is more than an additive approach that sums up multiple social categories or social processes, but rather considers the health impacts of multiple social identities or social positions.⁵⁹ That is, how experiences of advantage and disadvantage across multiple identities may influence health through the structuring of risks and opportunities needed for health and wellbeing.⁵⁸ For example, experiences of racism are often highly gendered, with boys and girls experiencing racism in different ways. Children and young people who are Aboriginal and Torres Strait Islander, or from an ethnic minority, and who are also disabled, living in a rural area, or are same sex attracted may also experience multiple forms of discrimination related to their multiple marginalised identities. While research is limited, recent analyses of the Speak Out Against Racism survey found males reported higher levels of racial discrimination than female students, students born overseas experienced more than those born in Australia, and students identifying as Christian or from a religious minority experienced racial discrimination more than those identifying as no religion.⁶⁰ Similarly, a US study among school students found boys experienced more racial discrimination than girls, including higher levels of being graded and being disciplined more harshly and being thought of as less smart because of their race.⁶¹

Racism and child and youth health

In Australia and throughout the world children and young people from Aboriginal and Torres Strait Islander and from minoritised ethnic groups experience enduring and pervasive health inequities that persist throughout life and across generations. These inequalities include higher rates of pre-term birth, low birth weight and infant mortality, earlier onset of illness, increased severity and progression of disease, higher levels of co-morbidities and impairment throughout life, higher mortality rates and poorer healthcare access and quality.^{62,63} These health inequalities continue over time and across contexts despite changes in diseases and health-related factors.¹ As a result, it is now increasingly acknowledged that racism is a critical determinant and a fundamental cause of health and health inequalities.^{1,2} Health inequalities, therefore, cannot be eliminated without addressing racism.^{1,2,64} This is arguably even more salient among children and young people given that children and youth are particularly vulnerable to racism's harms and that foundations for lifelong health are set early in life.⁴

Pathways by which racism impacts child and youth health

Racism is inherently complex in nature. Racism can also impact child and youth health in complex ways and through multiple pathways.

1) Racism leads to differential access to socioeconomic resources and to a broad range of societal resources and opportunities needed for health. Systemic racism within education, housing, employment, healthcare, the media and online, and in policing and criminal justice systems are key mechanisms by which racism can influence socioeconomic inequalities experienced by Aboriginal and Torres Strait Islander peoples and by some migrant and minoritised ethnic groups. However, while socioeconomic differences in health account for some health inequalities experienced by these groups, child health inequalities remain even after accounting for socioeconomic position.^{65,66}

2) Racism can increase exposure to, and exacerbate negative effects of, other risk factors for health. Racism initiates and sustains some types of stressors such as discrimination and historical trauma but it can also affect the levels, clustering and impact of stressors such as unemployment, financial stress, neighbourhood violence or physical/chemical exposures in residential and work environments.^{47,64} For example, childhood exposure to adversity and toxic stress is well documented as having lifelong impacts on health and wellbeing. A recent Australian study found that Aboriginal and Torres Strait Islander children, and children from ethnic minority backgrounds, experience higher levels of childhood adversity than their peers, and that this inequality remained even after accounting for socioeconomic position.⁶⁶ Rather than being interpreted as a deficit in these families and children, these findings highlight the way in which racism can drive higher exposure to stress and adversity even among young children.

3) Behavioural, physiological and psychological responses to racism, as well as individual and collective resilience, are also important mechanisms shaping health outcomes. These are critically important, but they must be understood within the larger context of race and racism and the basic causes, processes and pathways that precede them. For example, reduced healthy behaviours (e.g. exercise, diet, sleep) and/or increased unhealthy behaviours (e.g. substance misuse) either directly as stress-coping or indirectly via reduced emotional-regulation. Racism and exposure to associated stressors can also disrupt physiological regulatory systems and directly impact biological processes influencing factors such as blood pressure, inflammation, hormonal levels and even cellular ageing.

Children and young people are particularly vulnerable to racism's harms.²⁹

Racism harms child and youth health through direct exposure to racism and pathways of stressor exposure as well as through the structural and societal legacies of historical and contemporary racism on communities, families and carers and their access to resources and opportunities.⁴ A recent American Academy of Paediatrics statement highlights that the urgent need to address racism as a determinant of child and adolescent health in order to achieve health equity.²⁹

Systemic racism and child and youth health

Most research on racism and health – among adults and among children and young people – has focused on individual, interpersonal racial discrimination – that is, the stress of unfair treatment and self-reported racial discrimination.¹⁵ While this inequitable suffering and stress matters profoundly, a broader societal view is needed to understand, address and prevent structural racism and related harms.¹⁵ Critical attention is needed to integrate a focus on structural racism into medical and health literature and to achieve health equity and improve population health for children and young people, as well as their families and communities.¹⁵

As described above “Structural racism involves interconnected institutions, whose linkages are historically rooted and culturally reinforced. It refers to the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media [including online and social media], health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values and distribution of resources, which together affect the risk of adverse health outcomes.”¹⁵

Any discussion of systemic racism in Australia must start with colonisation and genocide of Aboriginal and Torres Strait Islander peoples and the creation of legal and tacit systems of racial oppression including dispossession from lands and forcible child removal, the legacies of which continue to this day.^{15,67} Past practices have a long-lasting reach, and while many former policies and practices have been formally revoked, contemporary practices of institutional racism in both the public and private sector continue, often not explicitly mentioning “race” but carrying racist intent or consequences, or both.¹⁵ Institutional racism in one sector reinforces it in other sectors, forming a large, interconnected system of structural racism whereby unfair discriminatory practices and inequities in the health and criminal justice systems and in labour and housing markets bolster unfair discriminatory practices and inequities in the educational system, and vice versa.¹⁵ These all have profound impacts on child and youth health, as well as health throughout the life-course and across generations.

For example, even though discrimination in the housing and rental market is no longer legal, it remains pervasive with numerous reports identifying those with Aboriginal and Torres Strait Islander or “foreign-sounding” names facing considerable barriers to obtaining and retaining housing.^{68,69} Strong evidence from audit studies shows racial discrimination in employment and recruitment, with Aboriginal and Torres Strait Islander, Italian, Chinese and Middle Eastern less likely to receive call backs than those with Anglo names.⁷⁰ These forms of institutional discrimination impact on the ability of Aboriginal and Torres Strait Islander and some ethnic minority families to access and accumulate socioeconomic resources and serves to reinforce and entrench persistent socioeconomic inequalities.

Policies of child removal, youth incarceration and policing also disproportionately impact Aboriginal and Torres Strait Islander children and youth people, as well as those from some ethnic minority backgrounds, and stereotype Aboriginal and Torres Strait Islander and African children and young people as violence prone and their families as neglectful or incompetent. The legacy of these policies is that 2,027 Aboriginal and Torres Strait Islander children, in Victoria are in out of home care (26% of children and young people in care in Victoria as of December 2018).⁷¹ 259 Aboriginal and Torres Strait Islander children and youth were under youth justice supervision throughout 2018-19, with a rate of incarceration 10 times higher than non-Aboriginal Children aged 10-17 years (Aboriginal and Torres Strait Islander rate – 79.4 Per 10,000 non-Indigenous Rate 8.3 per 10,000).⁷² Of the children who have come in contact with the justice system, Aboriginal and Torres Strait Islander children are more likely to have contact from a younger age. In 2018, of the Aboriginal and Torres Strait Islander alleged offenders 43.0% were aged 10-14 compared with 27.8% for non-Aboriginal and Torres Strait Islander youth.⁷³

Throughout the coronavirus pandemic in Victoria, South Sudanese and Aboriginal and Torres Strait Islander young people are overrepresented in the number of fines issued by police with 5% of all fines being handed out to people born in South Sudan and 4.7% of fines handed out to Aboriginal and Torres Strait Islander people.⁷⁴

Education policies and practices in schooling systems and institutions are also ways in which systemic and institutional racism powerfully influence the health of Aboriginal and Torres Strait Islander, and of some ethnic minoritised children and young people. Schools and education institutions have long been key sites of colonisation and of eradication of culture and language.⁷⁵ Curriculum content and pedagogical approaches have been, and continue to be, those of the majority. Aboriginal and Torres Strait Islander history and culture is often silenced, and/or misrepresented with deficit narratives, negative stereotypes, lower expectations⁷⁶ and disproportionate discipline all ways in which

systemic and institutional racism in education operates.⁷⁵ Migrant and ethnic minoritised groups also face systemic and institutional racism in education through curriculum and pedagogical approaches, discipline practices and stereotyping and academic expectations.^{77,78} Systemic and institutional racism in education influences child and youth health by limiting access to future socioeconomic resources and opportunities, as well as via the heightened stressor load and associated physiological, cognitive, mental health and behavioural impacts. As Bodkin-Andrews and Carlson identify, systemic and institutionalised racism and lifelong inequalities that exist for Aboriginal and Torres Strait Islander Australians ‘can often be perpetuated within the very education systems that should act as one of the strongest tools to redress such inequalities’.⁷⁵

Health care quality and access are further ways in which systemic racism influences child and youth health in Australia both directly and indirectly. Racism in the health care system leads to poorer health care access, quality of health care, and inequitable health and treatment outcomes for Aboriginal and Torres Strait Islander children, young people and their communities and is a major, outstanding priority.^{79,80} Bond and colleagues write ‘Both Aboriginal and Torres Strait Islander clients and clinicians have stories to tell of the violence of racism in the health system, of being cast in the category of less capable, less compliant, less deserving of care and less worthy of the category of human’. This then brings us to the coronial inquiry, the endgame of not caring; of neglect. Here, never let us forget the mothers, the children, the cousins and the spouses weeping outside coroner’s courts, bearing photos of their loved ones in their hands and on their clothing, simultaneously appealing for care and for justice.”⁶⁷ They continue drawing on Boyd et al⁴³ “How do we further explain the focus on the individual health behaviours or “choices” of Aboriginal and Torres Strait Islander peoples when we know ‘incessant racial health inequities across nearly every major health index reveal less about what patients have failed to feel and more about what systems have failed to do’. As Boyd and colleagues point out, ‘The solution to racial health inequities is to address racism and its attendant harms and erect a new health care infrastructure that no longer profits from the persistence of inequitable disease’.”

Australian children and young people from migrant and ethnic minoritised backgrounds also face higher barriers to health care access and levels of unmet need than the rest of the population.⁸¹

Cyber-racism is also increasingly a key way in which systemic racism can influence health, including via media and online representations of groups, which can often reinforce negative stereotypes and biases, and algorithms for healthcare, policing and other technological systems, which are often racially biased.⁸²

While systemic and institutional racism clearly operate in complex and multiple interrelated ways, here we identify 4 distinct but related ways systemic racism influences child and youth health in Australia as priorities for action: education quality and access, health care quality and access⁶⁷, discriminatory incarceration⁶⁷, and discriminatory child protection and out of home care systems.⁸³ Each of these pathways include actionable leverage points to reduce exposure to systemic racism and promote health equity.

Interpersonal racism and child and youth health

There is a growing body of evidence documenting effects of racial discrimination on child and adolescent health from infants and young preschoolers right through childhood and adolescence to young adulthood. Impacts of racial discrimination on mental health have been most commonly examined, with effects of discrimination on negative mental health, including depression, anxiety, behaviour difficulties as well as positive mental health such as self-esteem, life satisfaction and wellbeing.^{4,16}

Racial discrimination can influence mental health via psychological and behavioural responses such as hypervigilance, rumination, heightened threat perception and situation avoidance, and through dysregulation of biological stress responses including inflammation.⁸⁴

Links between racial discrimination and child and adolescent sleep are also emerging.⁸⁵ Evidence shows racial discrimination is associated with shorter sleep duration, increased sleep difficulties and sleep disruption, as well as increased sleep latency, that is taking longer to fall asleep at night.^{16,85-93} Sleep is increasingly recognised as an important dimension of child and adolescent health and development, associated with mental health, learning and education outcomes, as well as cardiometabolic risk.⁹⁴

Among adults experiences of racial discrimination have been associated with a range of cardiometabolic risk markers and outcomes, including hypertension, carotid intima-media thickness (a preclinical atherosclerosis phenotype), coronary artery calcification, blood pressure, adiposity and chronic inflammation.⁹⁵ Recent evidence is beginning to show similar findings among children and adolescents, with experiences of racial discrimination associated with markers of chronic inflammation, blood pressure and overweight and obesity in primary school children^{18,96} and in adolescents.^{17,25} Experiences of racial discrimination may be an important, yet under-explored, form of childhood adversity influencing childhood cardiometabolic risk.^{4,18,97} Experiences of racial discrimination have also been associated with increased cellular ageing in adolescents, with racial discrimination in late adolescence longitudinally associated with epigenetic ageing at 20-22 years of age among those not in family supportive environments.²⁴

While most evidence to date on the health effects of racial discrimination for children and young people focuses on direct experiences, there is growing evidence of the health harms associated with vicarious racial discrimination. That is, racial discrimination directed at others that may or may not be witnessed by children and young people.^{4,26} Both direct and vicarious racial discrimination can occur in person or online, with social media and online settings increasingly key settings for racism. Witnessing racial discrimination directed towards peers at school has been associated with social-emotional adjustment and sleep problems in 10-15 year olds in a large-scale Australian study.¹⁶ Caregiver experiences of racial discrimination have been associated with common childhood illnesses among children aged 7 years and under⁹⁸ and with social and emotional difficulties among children aged 7 to 11 years⁹⁹, with the impact of racism on caregiver mental health a key pathway by which racism experienced by carers impacts on the health of their children.⁹⁸ Caregiver experiences of racial discrimination have also been associated with child health care utilisation, with considerable potential for impact on child health outcomes.¹⁰⁰

Internalised racism and child and youth health

Internalised racism occurs when members of stigmatised racial/ethnic groups take on dominant beliefs and thoughts about their biological and/or cultural inferiority including self-stereotyping, embracing “Whiteness” and rejecting ancestral culture, as well as feelings of hopelessness, disengagement and helplessness.^{47,101} Internalised racism has received much less research attention than other forms and levels of racism.^{47,102} Internalised racism and self-stereotyping are terms used to describe the response of some members of stigmatised groups to the pervasive negative stereotypes about race in the larger society where they accept as true the dominant society’s beliefs about their biological and/or cultural inferiority.⁴⁷ Internalised racism can adversely affect health by fostering acceptance and personal endorsement of beliefs about the inherent deficiencies of one’s self and one’s group. This then influences responses across behavioural, psychological and physiological levels as well as impacting individual and collective resilience.

Among adults, internalised racism can lead to lower self-esteem and psychological wellbeing and have broad negative effects on health by adversely affecting identity, self-confidence and health behaviours.¹⁰³ Internalised racism has been positively associated with alcohol consumption, psychological distress, being overweight, abdominal obesity, blood pressure and fasting glucose.¹⁰⁴ One study found a positive association between internalised racism and violence and delinquent behaviour among adolescents.¹⁰⁵ This could be seen as an example of a behavioural response via everyday resistance in the form of defiance and non-compliance, and/or a psychological response via expression of negative emotions. Another study among Black American men found that internalised racism interacted with perceived discrimination to increase cardiovascular disease (CVD) risk¹⁰⁶ and another that internalised racism interacted with perceived discrimination to affect telomere length.¹⁰⁷ Far more work is needed to explore how this influences children and young people in Australia.

Stereotype threat is another mechanism by which racism in the larger culture affects stigmatised populations. This psychological response occurs when people are potentially viewed or evaluated in reference to a negative stereotype about a group to which they belong.¹⁰⁸⁻¹¹⁰ Importantly, this stereotype threat phenomenon only occurs when a group is stereotype vulnerable because of the presence of a larger stigma or cultural stereotype of their group. When an individual believes his or her ability is being evaluated and when he or she cares about the domain of evaluation (e.g. math or technology performance, cognitive ability etc.), stereotype threat can result in people performing less well than they are capable.¹¹¹⁻¹¹³ For example, making gender salient for Asian American women reduces academic performance, but making their race salient enhances it.¹¹⁴

Stereotype threat can adversely affect health indirectly through its negative impact on educational attainment. It may also negatively affect health in at least two other ways. First, the stress created by stereotype threat could lead to the activation of the stress process with all of its physiological consequences. One experimental study found that the activation of stereotype threat led to increases in blood pressure for Black but not White students.¹¹⁵ Other limited evidence indicates that the activation of the stigma of inferiority can increase anxiety, reduce self-regulation and impair decision-making processes in ways that can increase risk behaviours such as overeating and aggressive behaviour.¹¹⁶ Second, stereotype threat can adversely affect the quality of the patient-provider relationship. Because stereotype threat can impair an individual's communication abilities, in clinical encounters it can lead to the discounting of information from the provider, lower levels of adherence and delays or failure to obtain needed medical care.¹¹⁷ Again, there is a need for research on stereotype threat among Australian children and young people.

Self-reported racial discrimination among 5-25 year old Australians (2016-2020)

Self-reported experiences of racial discrimination are a form of psychosocial stress that have adverse impacts on mental and physical health for children and youth across populations and contexts. In focusing here on self-reported experiences of racial discrimination we recognise that such experiences are only one expression and indicator of the wider system of racism. Systemic and institutional racism are profoundly important and structural racism is embedded in the systems, structures and institutions of society with long-lasting health impacts. While many self-reported experiences of racial discrimination are the flow-on effects of structural, systemic and institutional racism, such data cannot be considered equivalent to, or measures of, the wider system of racism nor do they fully capture the far-reaching impacts of racism across the systems and institutions of society. Recent reports documenting over-policing of Aboriginal and Torres Strait Islander and ethnic minority youth people during injustices in incarceration highlight some of these structural impacts. psychosocial stressors that mark the lives of many children and young people, and their families and communities and contribute substantially to the health inequities they experience.

This report focuses on Australian data collected in the last 5 years (2016-2020) among children and young people and their carers that includes self-reported measures of racial discrimination, reported by children and young people themselves or by their carers. Studies that collect data on discrimination not attributed to Indigeneity or racial/ethnic background are not included.

Aboriginal and Torres Strait Islander children and young people

Four studies collected between 2016 and 2020 that included measures of self-reported racial discrimination among Aboriginal and Torres Strait Islander children and young people are included. Three of these are ongoing population cohort studies (LSAC, LSIC, and Next Generation) and one a large-scale population cross-sectional study (SOAR). Two only include Aboriginal and Torres Strait Islander children and young people (LSIC, NG) and two are representative of the Australian (LSAC) and NSW and Victorian (SOAR) population.

Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC)

Study overview

LSIC is a national longitudinal survey of Aboriginal and Torres Strait Islander children designed to follow the development of these children across a range of domains and to capture the socioeconomic and cultural background of their families.¹²⁰ In brief, LSIC used a multi-stage clustered sampling method across 11 sites to recruit a non-representative national sample of Aboriginal and Torres Strait Islander children into two cohorts defined by age. LSIC aimed to recruit 5-10% of the total Australian population of Aboriginal and Torres Strait Islander children aged 0.5-2 years for the birth cohort and 3.5-5 years for the child cohort at baseline (2008). Children participating in LSIC are followed up annually. In Wave 10 collected in 2017 when the B-cohort were 9.5-11 years and the K-cohort were 12.5-14 years, a detailed range of measures of racial discrimination (both parent-report and child-report) were collected. Wave 10 is the latest LSIC release available.

Key findings

Parent-reported racial discrimination

In total, there were 1215 Aboriginal and/or Torres Strait Islander children (both B-cohort and K-cohort) participating in the survey at Wave 10. Among the total sample, 14.5% to 51.7% of Parent 1 (i.e. primary carer) reported experiencing racism to some extent in their personal experiences. 87.2% to 92.8% of Parent 1 reported experiencing racism in macro experiences to some extent, and 84.4% to 91.3% of Parent 2 reported experiencing racism in macro experiences to some extent (see Figure 1.1 to 1.3).

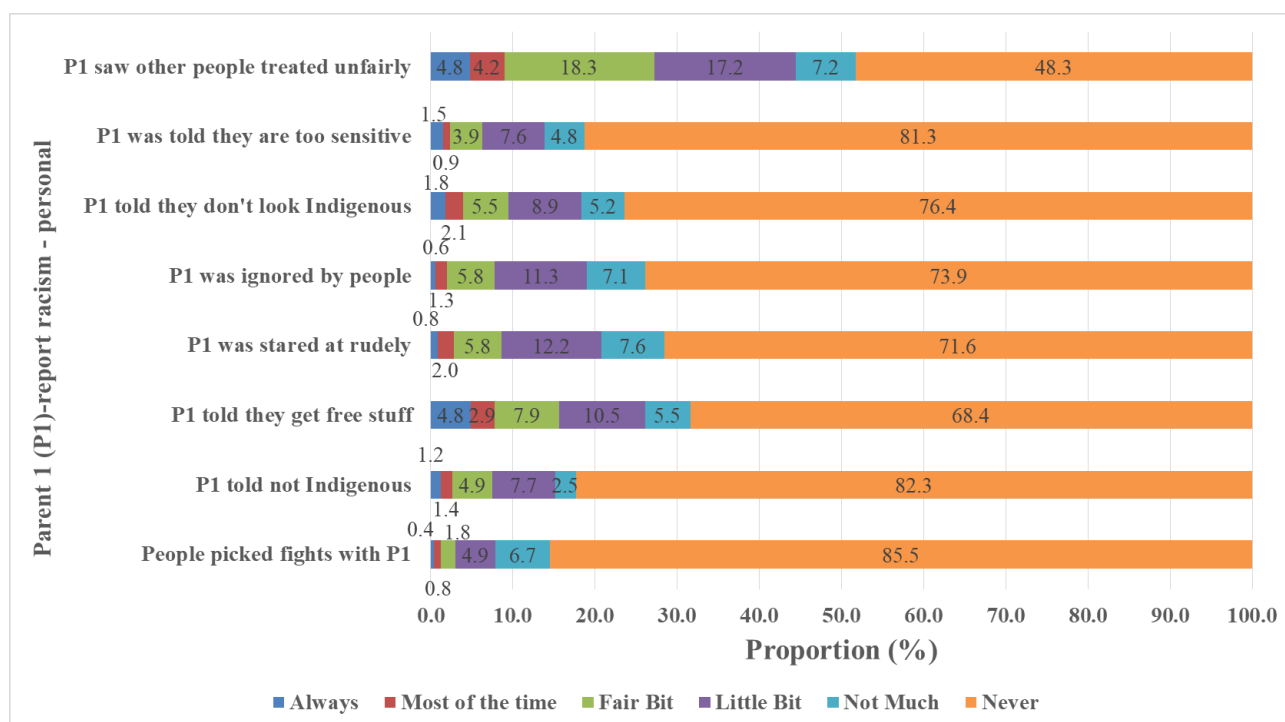


Figure 1.1 Self-reported interpersonal racial discrimination by parent/carers of Aboriginal and/or Torres Strait Islander children in LSIC (reported by Parent 1)

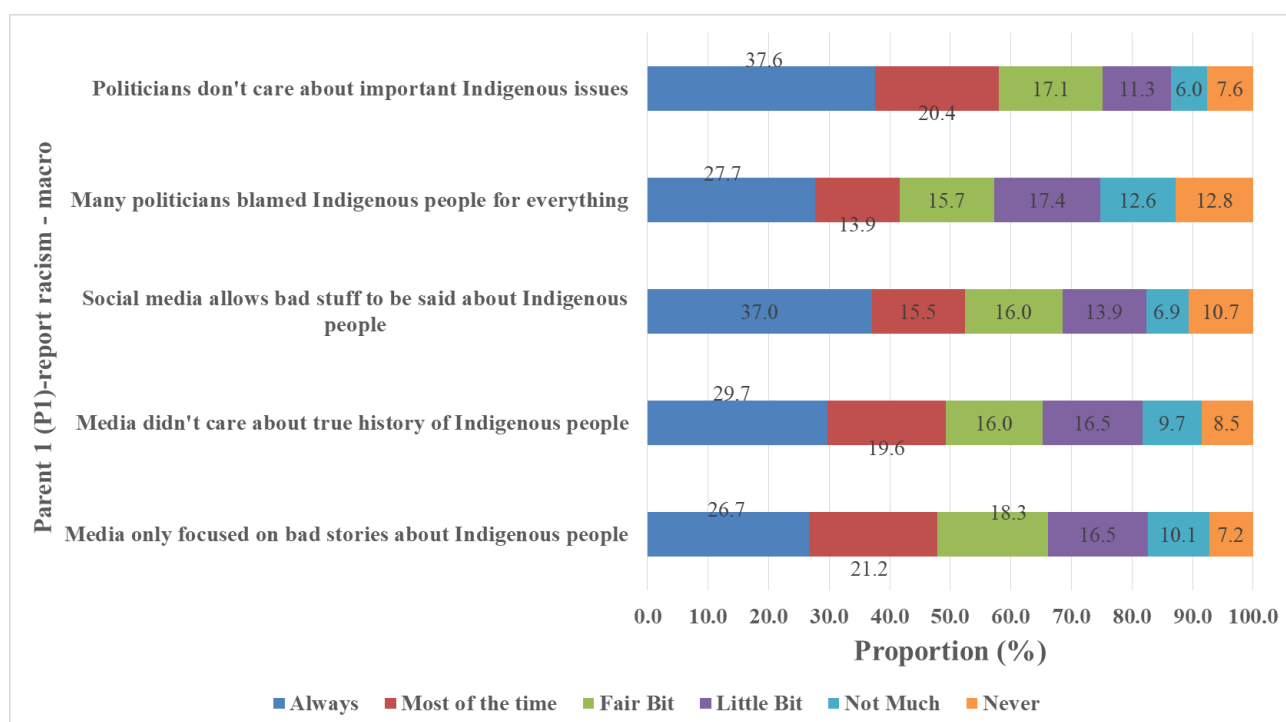


Figure 1.2 Self-reported macro racial discrimination by parent/carers of Aboriginal and/or Torres Strait Islander children in LSIC (reported by Parent 1)

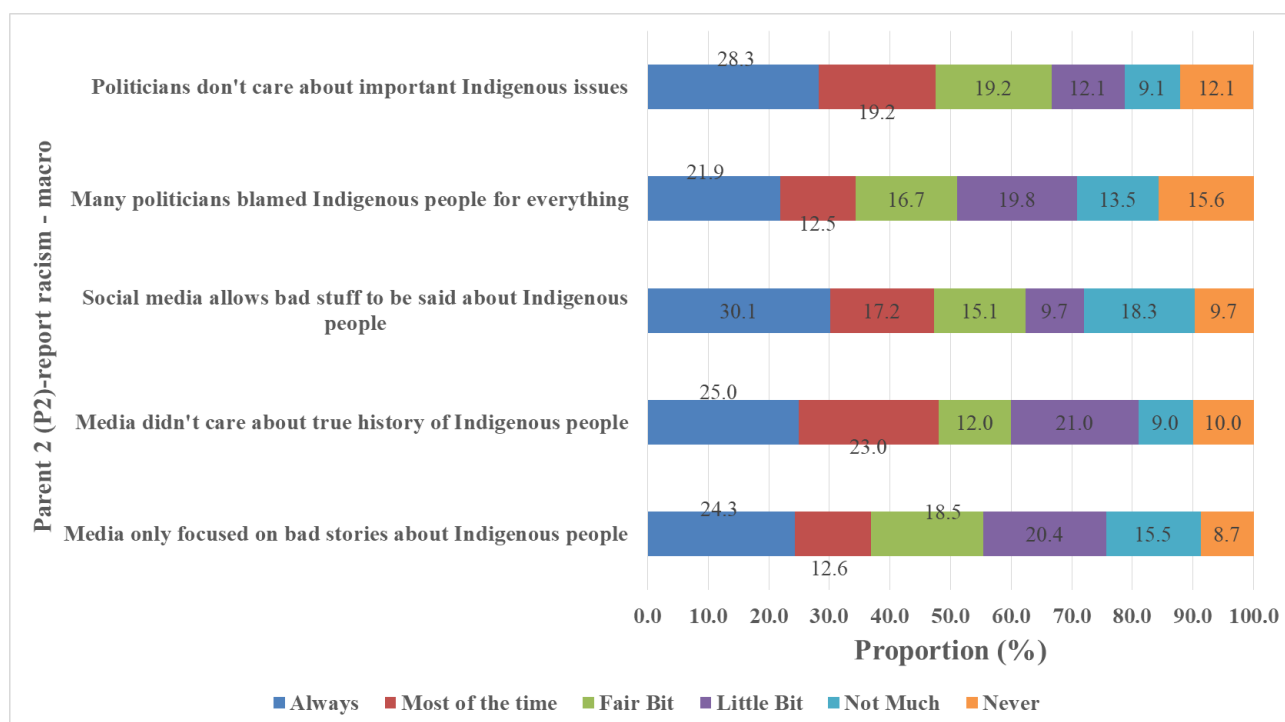


Figure 1.3 Self-reported macro racial discrimination by parent/carers of Aboriginal and/or Torres Strait Islander children in LSIC (reported by Parent 2)

Child-reported racial discrimination

In the K-cohort, there were 514 Aboriginal and/or Torres Strait Islander children participating in the survey at Wave 10. The proportion of children experiencing racism to some extent in their personal experiences ranged from 12.8% to 29.5%. At school, 25.9% to 44.1% reported experiencing racism by their teachers to some extent. 45.8% to 58.8% of children reported experiencing racism in macro experiences to some extent. Among those who were bullied (n=394), 7.6% of children reported they were always bullied because they were Aboriginal and Torres Strait Islander and 13.2% for those who were sometimes bullied for this reason. (see Figure 1.4 to 1.7).

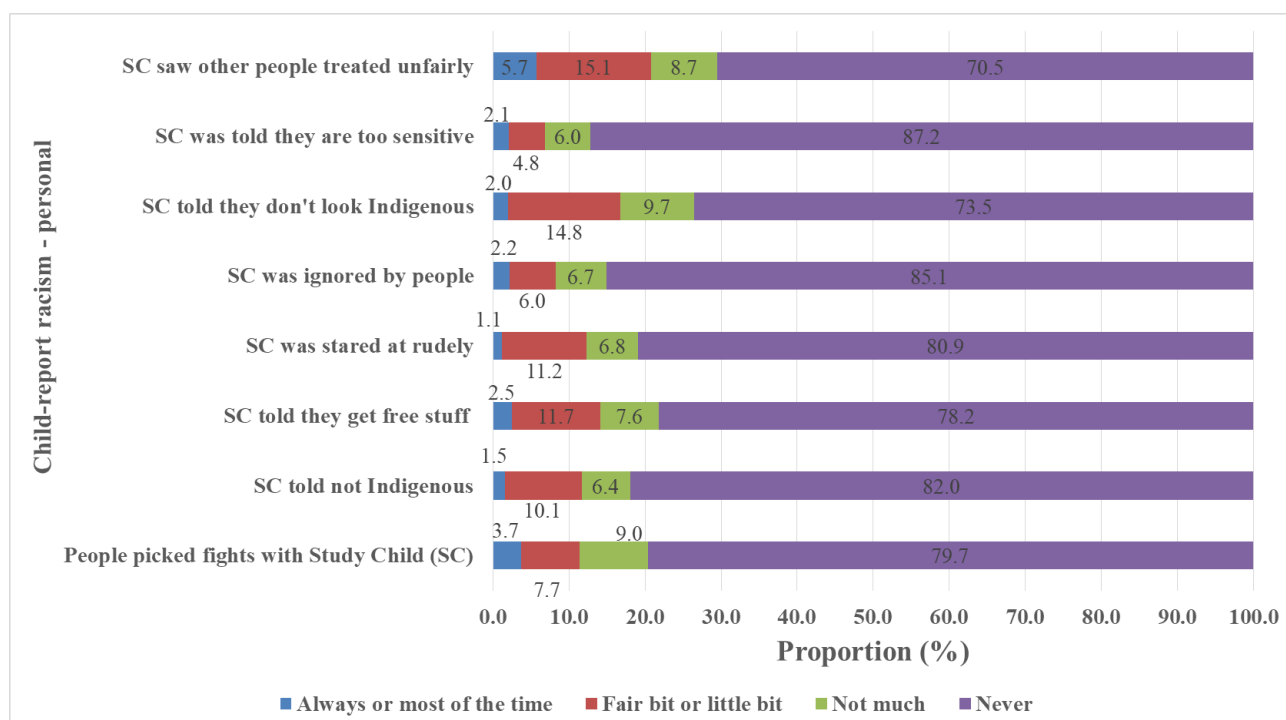


Figure 1.4 Self-reported interpersonal racial discrimination among Aboriginal and/or Torres Strait Islander children in LSIC, reported by Study Child (SC)

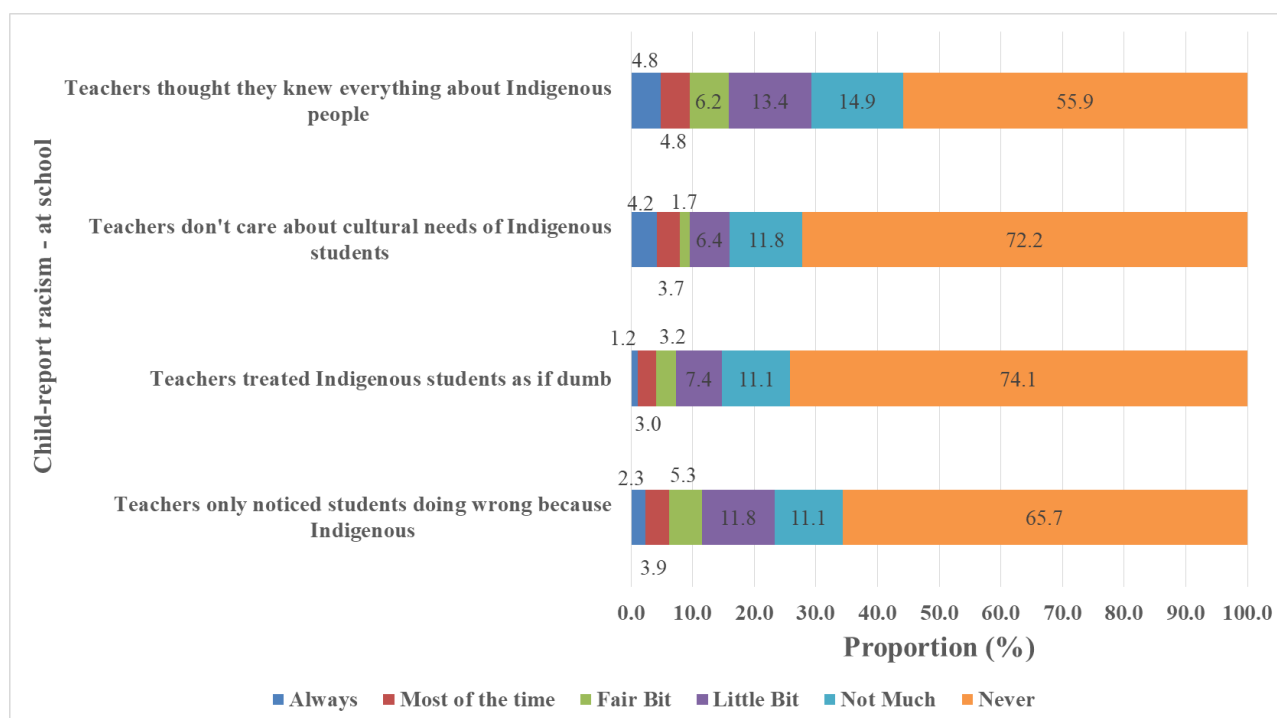


Figure 1.5 Self-reported racial discrimination at school among Aboriginal and/or Torres Strait Islander children in LSIC, reported by Study Child (SC)

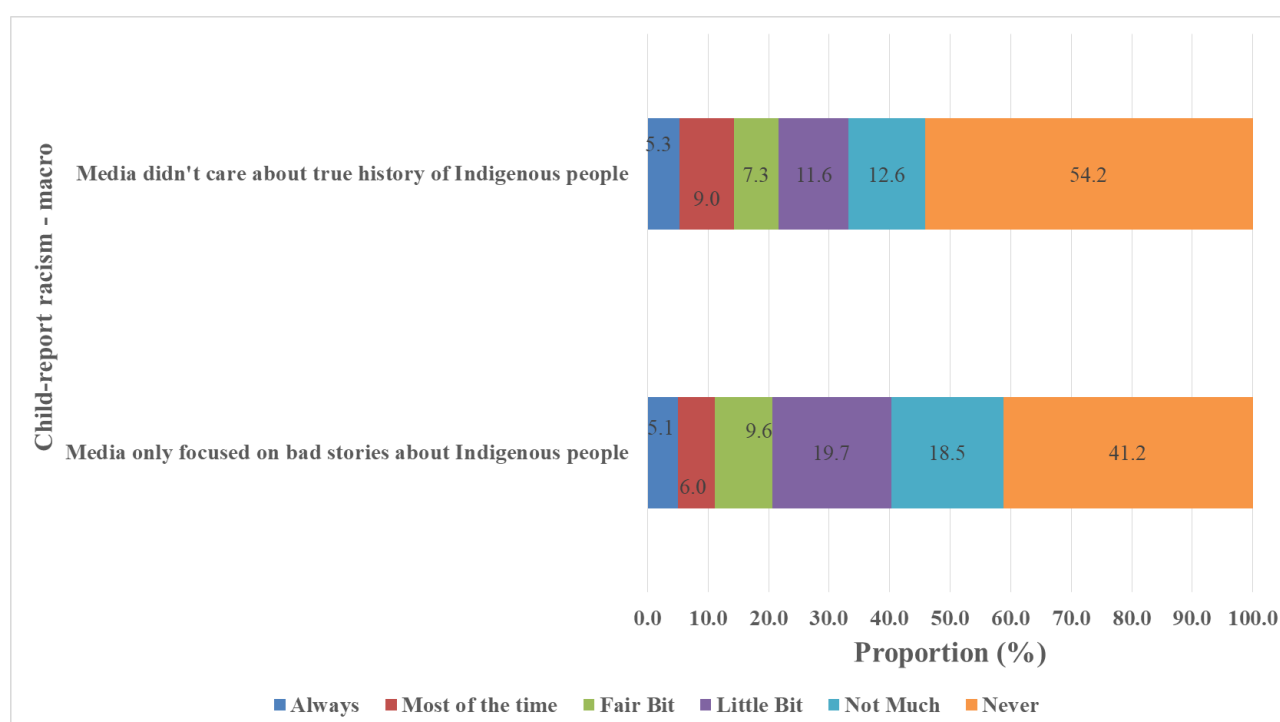


Figure 1.6 Self-reported macro racial discrimination among Aboriginal and/or Torres Strait Islander children in LSIC, reported by Study Child (SC)

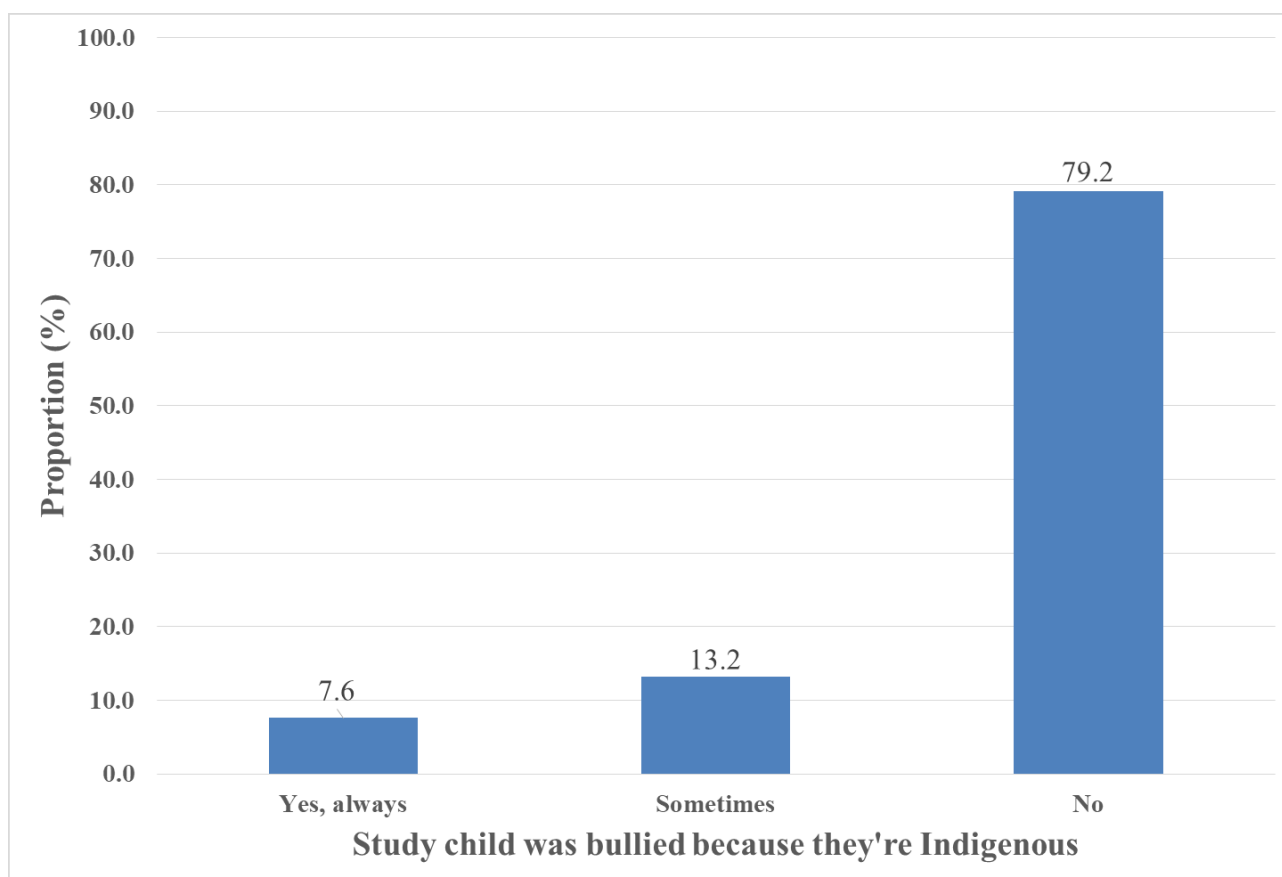


Figure 1.7 Proportion of Aboriginal and Torres Strait Islander children and young people who were bullied because they were Aboriginal and Torres Strait Islander, reported by Study Child (SC) in LSIC

The Next Generation Youth Wellbeing Study

Study overview

The Next Generation study is a new and large Aboriginal-led prospective cohort study of Aboriginal and Torres Strait Islander adolescents aged 10-24 years from rural, remote and urban areas, supported by foundational qualitative work.¹²¹ Rather than focusing on the early childhood years (e.g., LSIC), the Next Generation cohort is an adolescent-specific cohort and provides a wider range of health information through surveys, age-specific clinical assessments and linkage to administrative data sources. To date, 1309 Aboriginal and Torres Strait Islander adolescents aged 10-24 years have been recruited from 3 sites (Alice Springs n=82; Western Australia n=868, and New South Wales n=359) using different strategies during April 2018 to June 2020. More than half (59.9%; n=784) of adolescents are from the younger age group (10-15 years). Participants will receive follow-up surveys approximately two years after their baseline visit. Next Generation includes both direct and vicarious racial discrimination items, reported by Aboriginal and Torres Strait Islander adolescents themselves.

Key findings

Among the younger cohort (aged 10-15 years), 38% reported experiencing name-calling at least once or twice, 30% reported being left out, and 19% reported some form of physical discrimination including being spat on, pushed, or hit (see Figure 2.1). Fewer adolescents in the older cohort (aged 15-24 years) reported experiencing each of these forms of discrimination at least once or twice, with 34% experiencing name-calling, 20% experiencing being left out, and 10% being physically discriminated against. Adolescents in the older cohort were asked about two additional forms of discrimination they might have experienced. 21% reported experiencing poor service at least once or twice, and 25% had been hassled by police. At least some adolescents in both age groups experienced each of these forms of discrimination several times a week or more (ranging from 1-3%).

A considerably greater proportion of adolescents in this study reported experiencing various forms of discrimination vicariously. As shown in Figure 2.2, nearly half of younger Aboriginal and Torres Strait Islander adolescents experienced bad treatment (48%) and name-calling (48%) of others either sometimes or often, while 36% experienced others being left out and 31% experienced others being discriminated against physically. Over half of the sample of older adolescents experienced bad treatment of others (63%), others being left out (55%), name-calling of others (59%), and discrimination of others in the media (53%) either sometimes, most of the time or always. A substantial proportion (from 6-13%) reported these vicarious experiences as “always” happening.

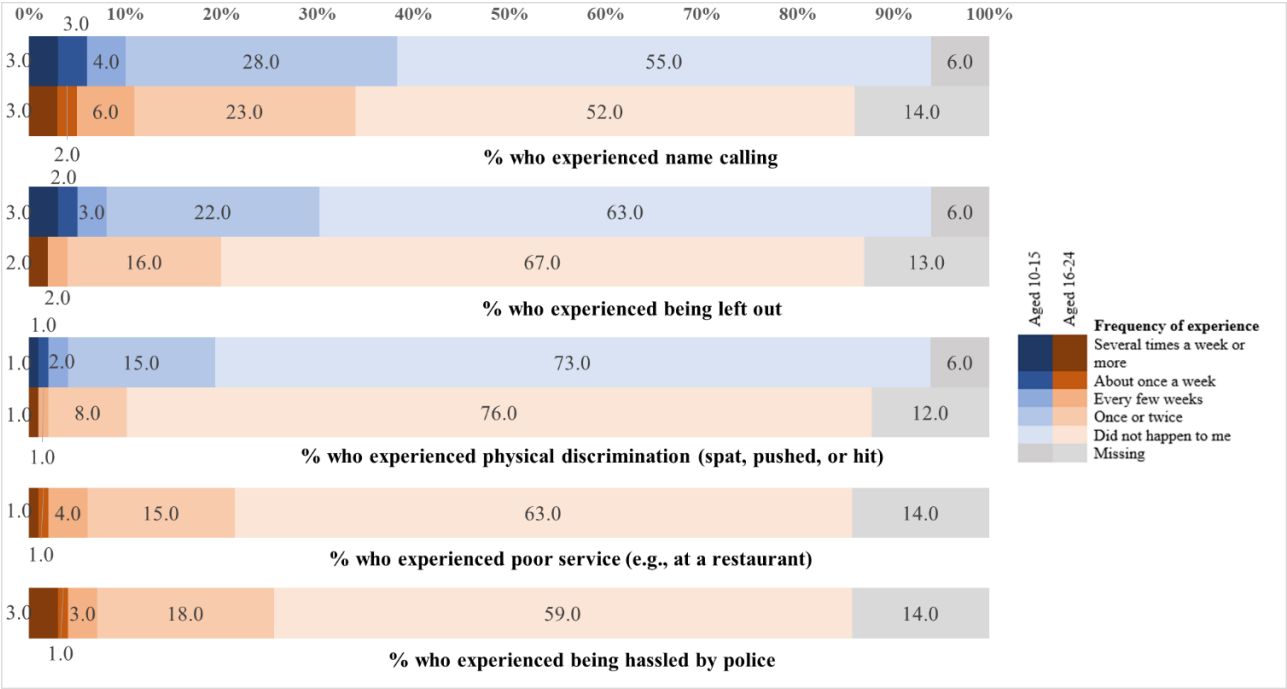


Figure 2.1 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to direct racial discrimination in Next Generation

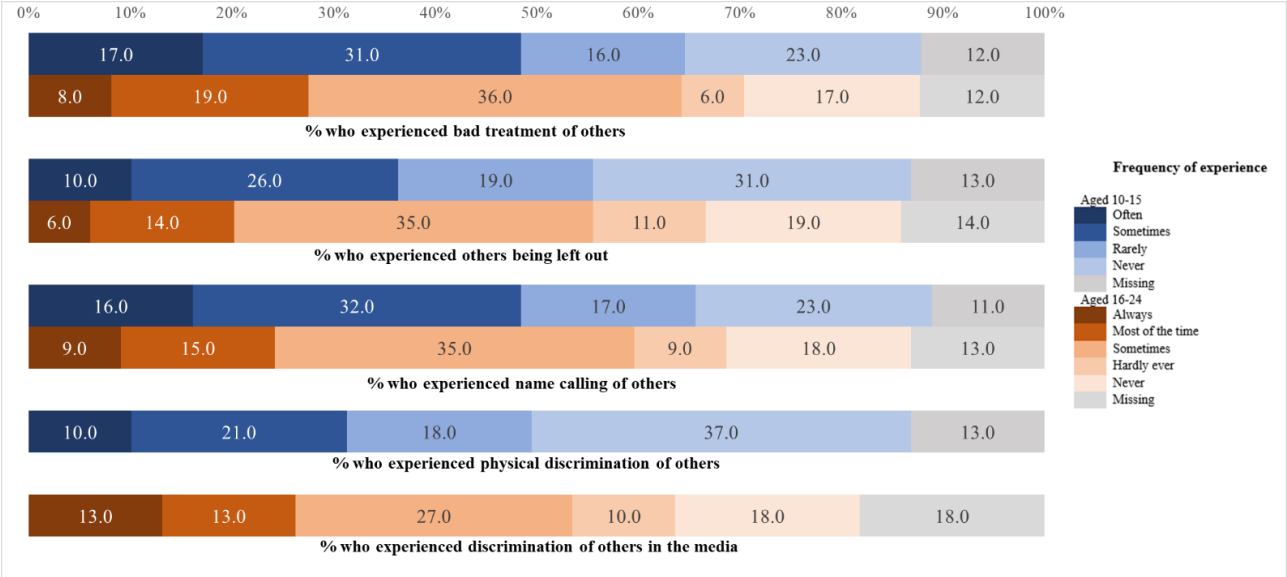


Figure 2.1 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to vicarious racial discrimination in Next Generation

Speak Out Against Racism (SOAR) student surveys

Study overview

The SOAR project is the first large scale population-representative study on experiences and attitudes to racism and racial bullying and on bystander responses to racism and racial discrimination (self-report) among Australian students in government schools in New South Wales (NSW) and Victoria.²⁷ The SOAR student survey was completed in 2017 by 4664 primary and secondary students aged 10–15 years across 23 schools: 2081 students in NSW and 2583 students in Victoria. In the total SOAR sample, 8.8% (409/4664) of students were identified as Aboriginal and/or Torres Strait Islander (6.9% (179/2583) of the Victorian sample). We considered sample weights for all estimation of the prevalence of racial discrimination to ensure our samples were representative of the target population.

Key findings

Overall, around half (50.1%) of Aboriginal and Torres Strait Islander students reported direct experiences of any racial discrimination (by peers 42.7%, by teachers 20.7%, in society 37.0%). 71.7% of students reported any vicarious racial discrimination, defined as seeing other students being treated unfairly by their peers (59.5%) or teachers (51.4%) because of their racial, ethnic or cultural background. In Victoria, 47.1% Aboriginal and Torres Strait Islander students reported direct experiences of any racial discrimination and 64.7% reported any vicarious racial discrimination (See Figure 3.1). Figure 3.2 and Figure 3.3 show the prevalence of direct and vicarious racial discrimination by each measurement item of racial discrimination.

In terms of direct experience of racial discrimination, boys (50.9%) reported slightly higher levels of any racial discrimination than girls (47.1%). Students in Year 5–6 (51.6%) reported higher levels of direct racial discrimination than those from Year 7–9 (45.3%). In terms of vicarious discrimination, there were similar findings by gender (boys 72.0%; girls 70.5%) and Year level (Year 5–6 76.8%; Year 7–9 55.2%) (see Appendix 1 for more details).

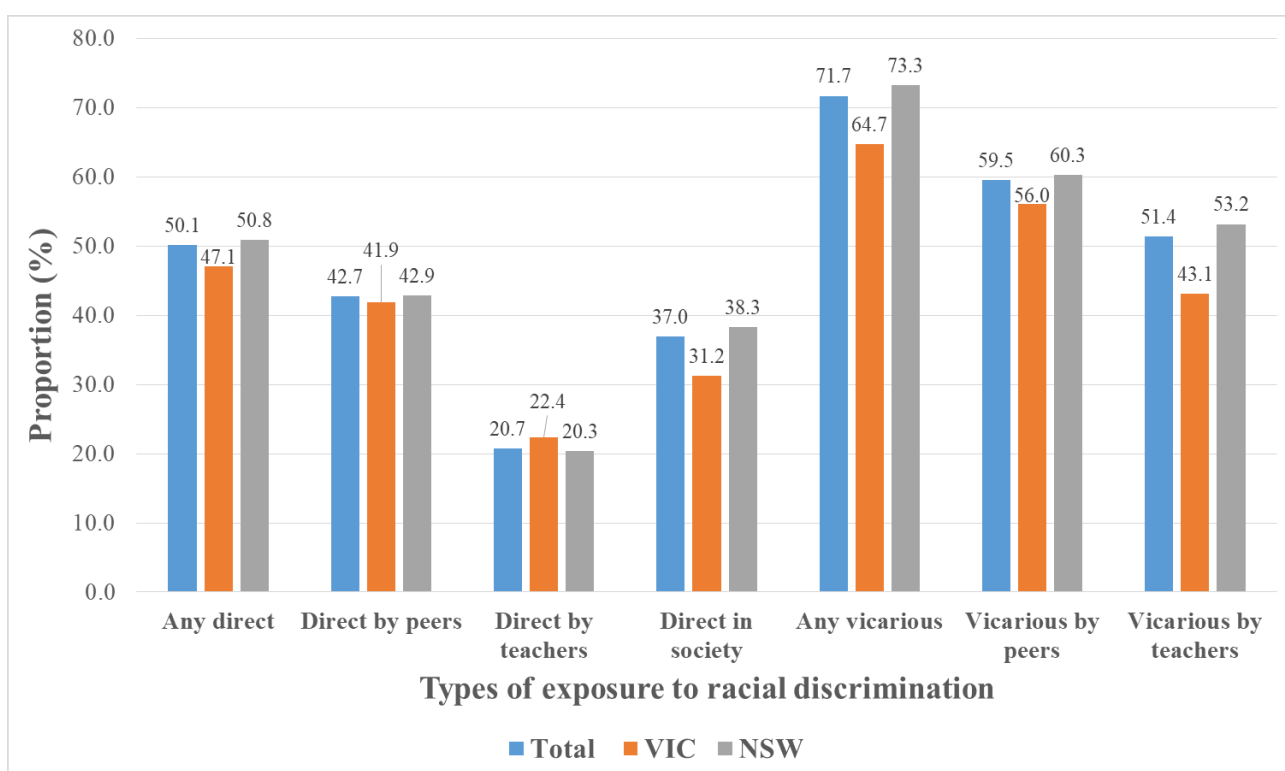


Figure 3.1 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to any racial discrimination in SOAR

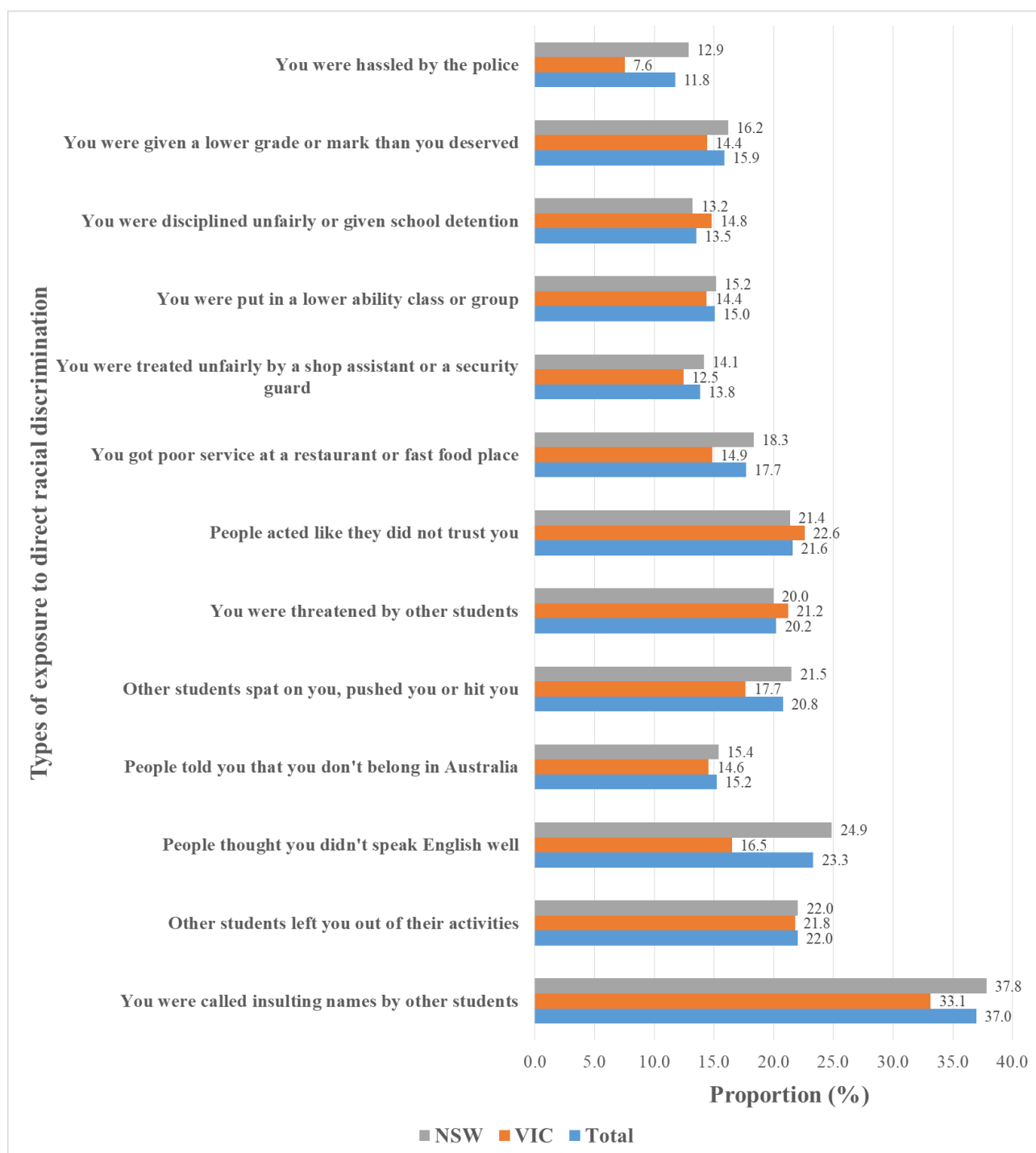


Figure 3.2 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to direct racial discrimination in SOAR by each measurement item

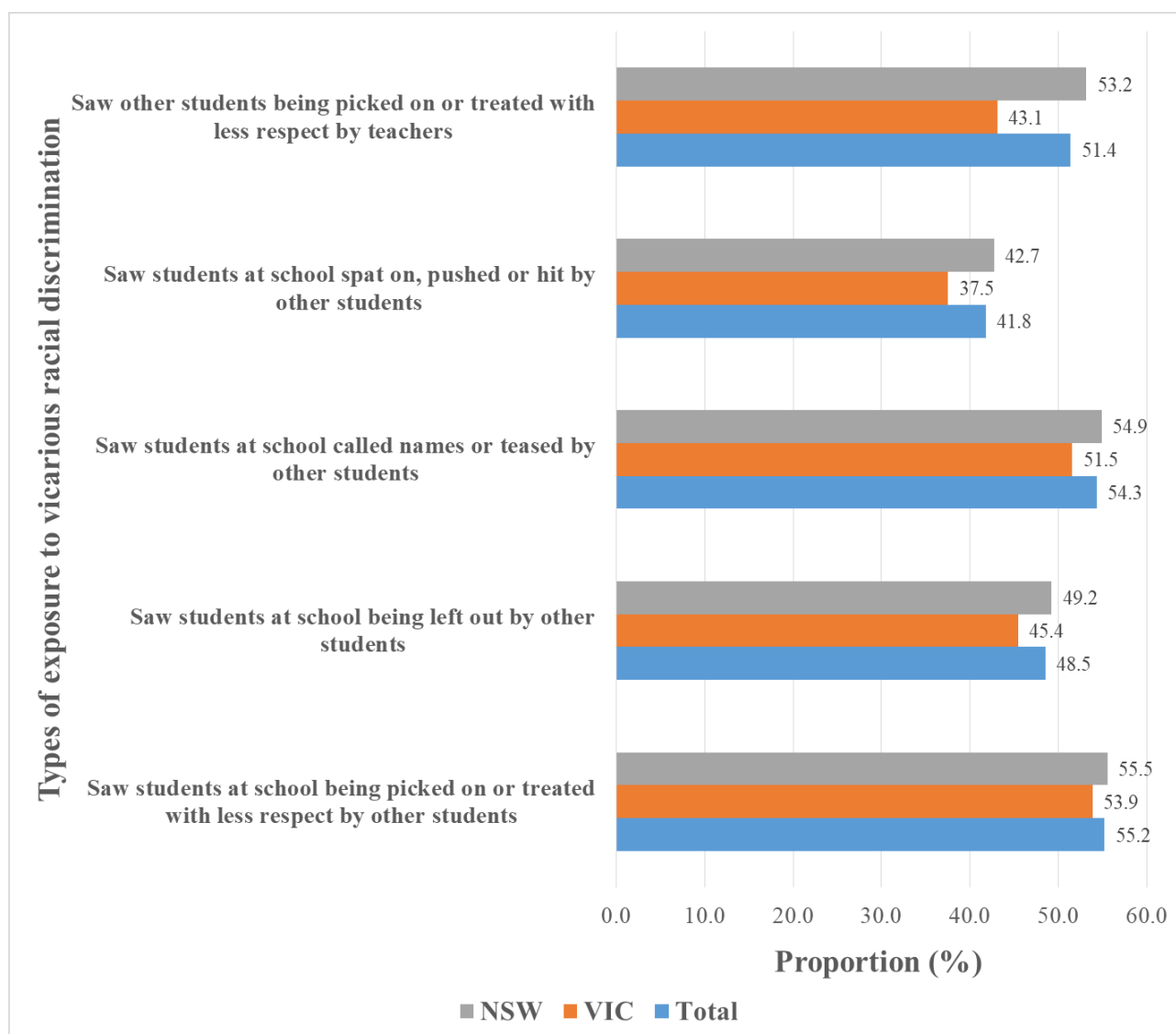


Figure 3.3 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to vicarious racial discrimination in SOAR by each measurement item

Longitudinal Study of Australian Children (LSAC)

Study overview

LSAC is a nationally representative sample of two cohorts of Australian children – the birth cohort (B-cohort) of 5107 infants, and the kindergarten cohort (K-cohort) of 4983 4-year-olds – each of which commenced in May 2004.¹²² In short, a two-stage clustered design was employed to select a sample that was broadly representative of all Australian children except those living in remote areas. LSAC data has been collected every two years. In both cohorts (B-cohort: Wave 7; K-cohort: Wave 5-7), LSAC includes 3 self-report items of direct experiences of racial discrimination. Wave 7 (2016) is the latest LSAC release available for both cohorts. Among the Wave 7 samples, 2.6% (87/3381) of the B-cohort and 2.3% (70/3089) of the K-cohort were identified as Aboriginal and/or Torres Strait Islander. We considered sample weights for all estimation of the prevalence of racial discrimination to ensure our samples were representative of the target population.

Key findings

In the B-cohort, 30% of Aboriginal and/or Torres Strait Islander children (30.1%) reported direct racial discrimination as shown in Figure 4.1. Aboriginal and/or Torres Strait Islander children reported higher levels of racial discrimination if they were boys, from the older age group, living with a primary carer who completed Year 12 and living in the metropolitan areas (See Appendix 1 for more details).

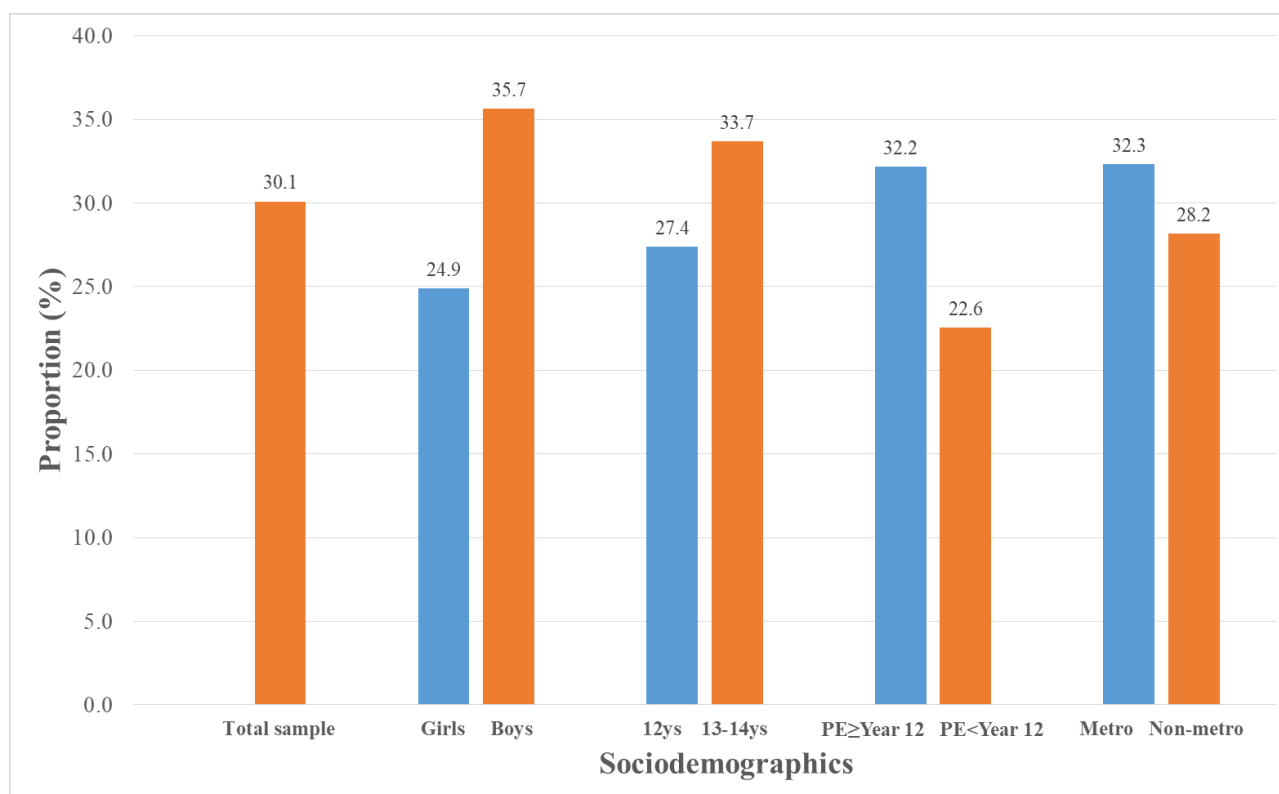


Figure 4.1 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to racial discrimination in LSAC B-cohort Wave 7 samples

(Notes: PE refers to Primary carer's highest education level)

In the K-cohort, we also examined the prevalence of direct racial discrimination when children were at aged 16-17 years (Wave 7). 19% of Aboriginal and/or Torres Strait Islander children (19.9%) reported direct racial discrimination. As shown in Figure 4.2, Aboriginal and/or Torres Strait Islander children reported higher levels of racial discrimination if they were girls, from the younger age group, living with a primary carer who did not complete Year 12 and living in the non-metropolitan areas (See Appendix 1 for more details).

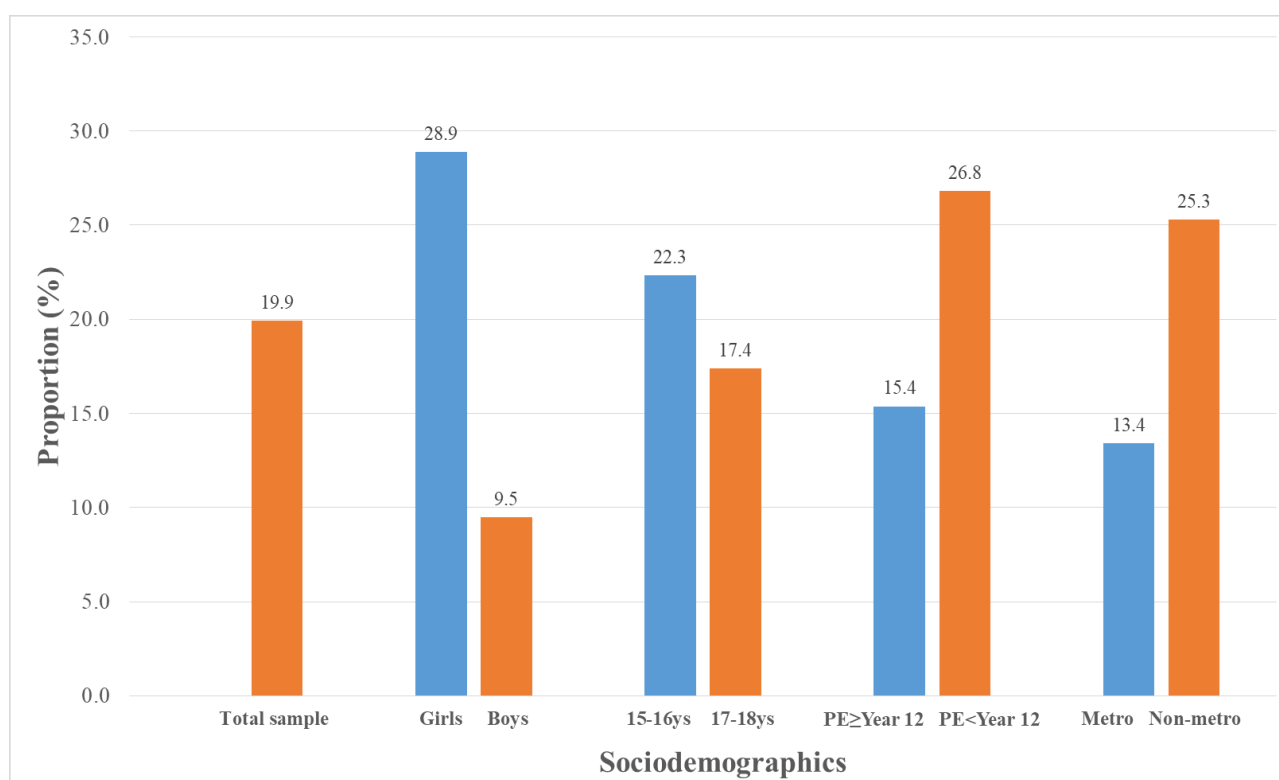


Figure 4.2 Proportion of Aboriginal and/or Torres Strait Islander children and young people exposed to racial discrimination in LSAC K-cohort Wave 7 samples

(Notes: PE refers to Primary carer's highest education level)

Ethnic minoritised and migrant children and young people

Four studies collected between 2016 and 2020 that included measures of self-reported racial discrimination among minoritised and migrant children and young people are included. One of these is an ongoing population cohort study (LSAC) and one a large-scale population cross-sectional study (SOAR), both of these are population-representative studies. Two studies were collected in the context of coronavirus impacts on young people and while providing unique and important data have small sample size (Hidden Costs - CMY) and lack of sociodemographic measures (Swimming with sandbags - UNICEF).

Speak out against racism (SOAR) student surveys

Study overview

The SOAR project is the first large scale population-representative study on experiences and attitudes to racism and racial bullying and on bystander responses to racism and racial discrimination (self-report) among Australian students in government schools in NSW and Victoria.²⁷ The SOAR student survey was completed in 2017 by 4664 primary and secondary students aged 10-15 years across 23 schools: 2081 students in NSW and 2583 students in Victoria. In the total SOAR sample, 34.3% (1599/4664) of the SOAR sample were identified from ethnic minoritised backgrounds, (36.9% (954/2583) of the Victorian sample). We present prevalence by detailed self-reported ethnicity which is a unique contribution of this study.

Key findings

Children from Pacific/Maori backgrounds

Among the total SOAR sample, there were 206 children from Pacific/Maori backgrounds. 61.0% of children from Pacific/ Maori backgrounds reported direct experiences of any discrimination (45.8% by peers, 16.8% by teachers and 32.9% in society). 77.2% of children who identified as Pacific/Maori reported any vicarious racial discrimination (66.3% by peers and 71.1% by teachers). In Victoria, 61.9% of Pacific/Maori children reported experiencing any direct discrimination (46.0% by peers, 28.6% by teachers, and 44.4% in society). 79.7% reported any vicarious racial discrimination (68.1% by peers and 62.2% by teachers) (see Figure 5.1). Figure 5.2 and Figure 5.3 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

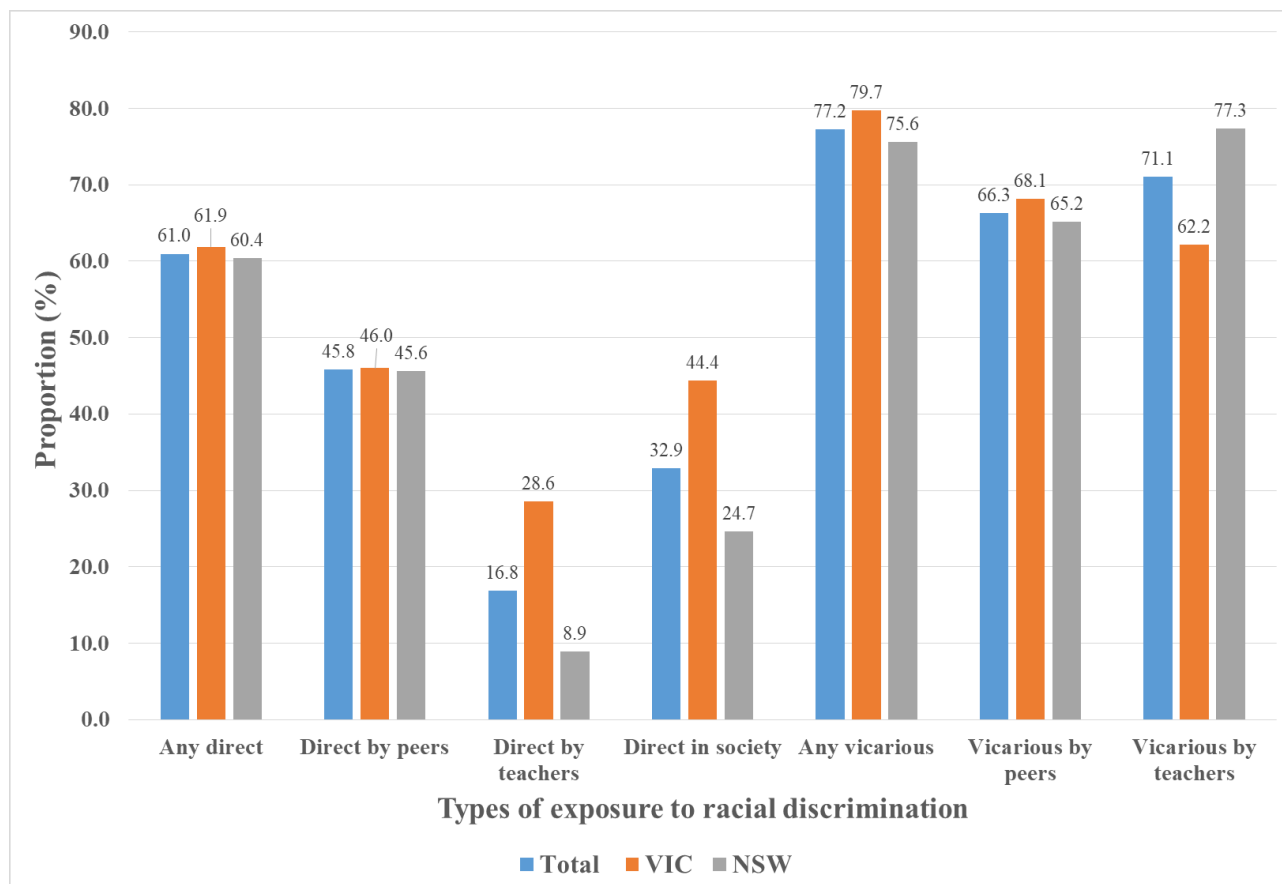


Figure 5.1 Proportion of Pacific/Maori children exposed to any racial discrimination in SOAR

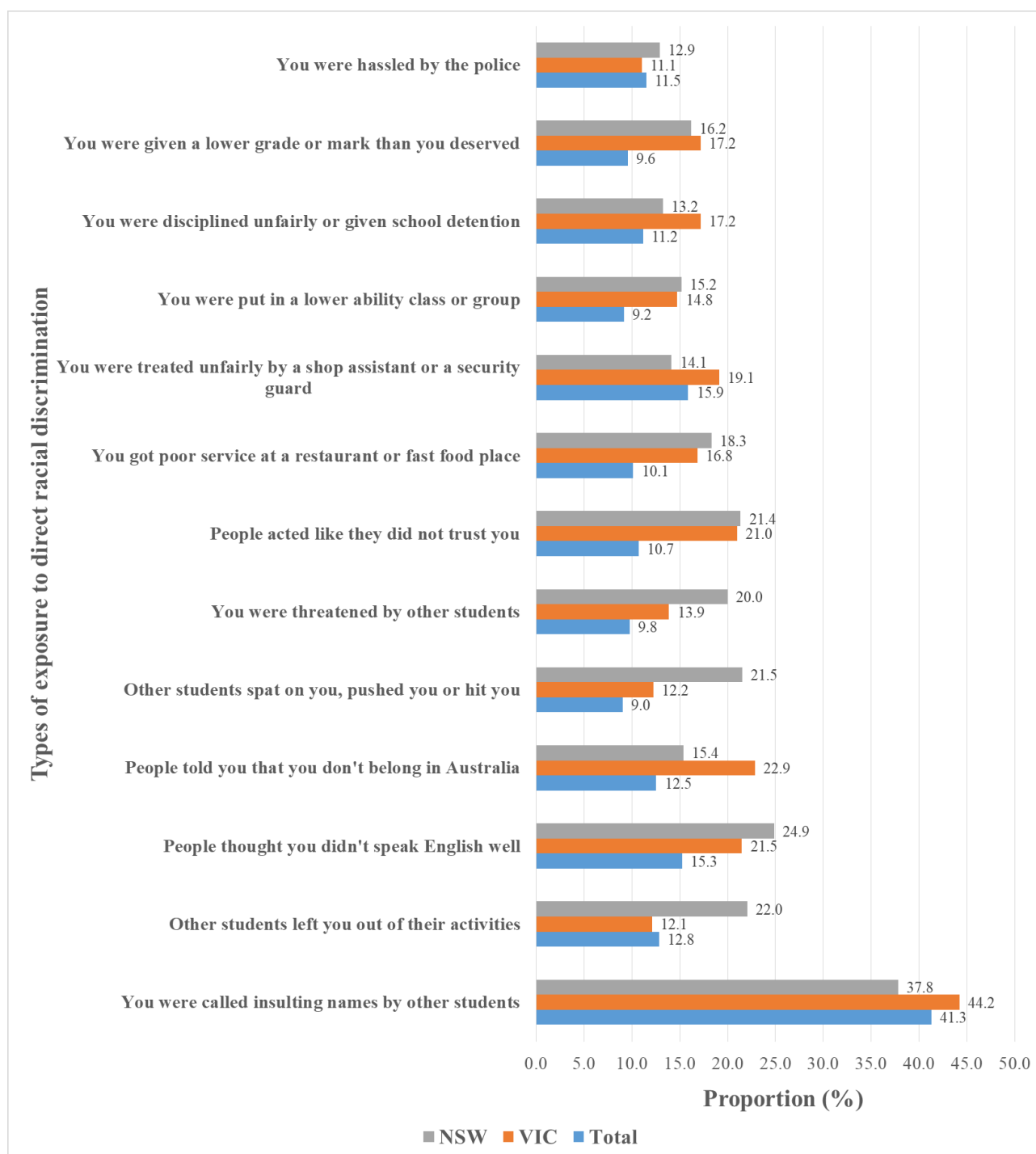


Figure 5.2 Proportion of Pacific/Maori children exposed to direct racial discrimination in SOAR by each measurement item

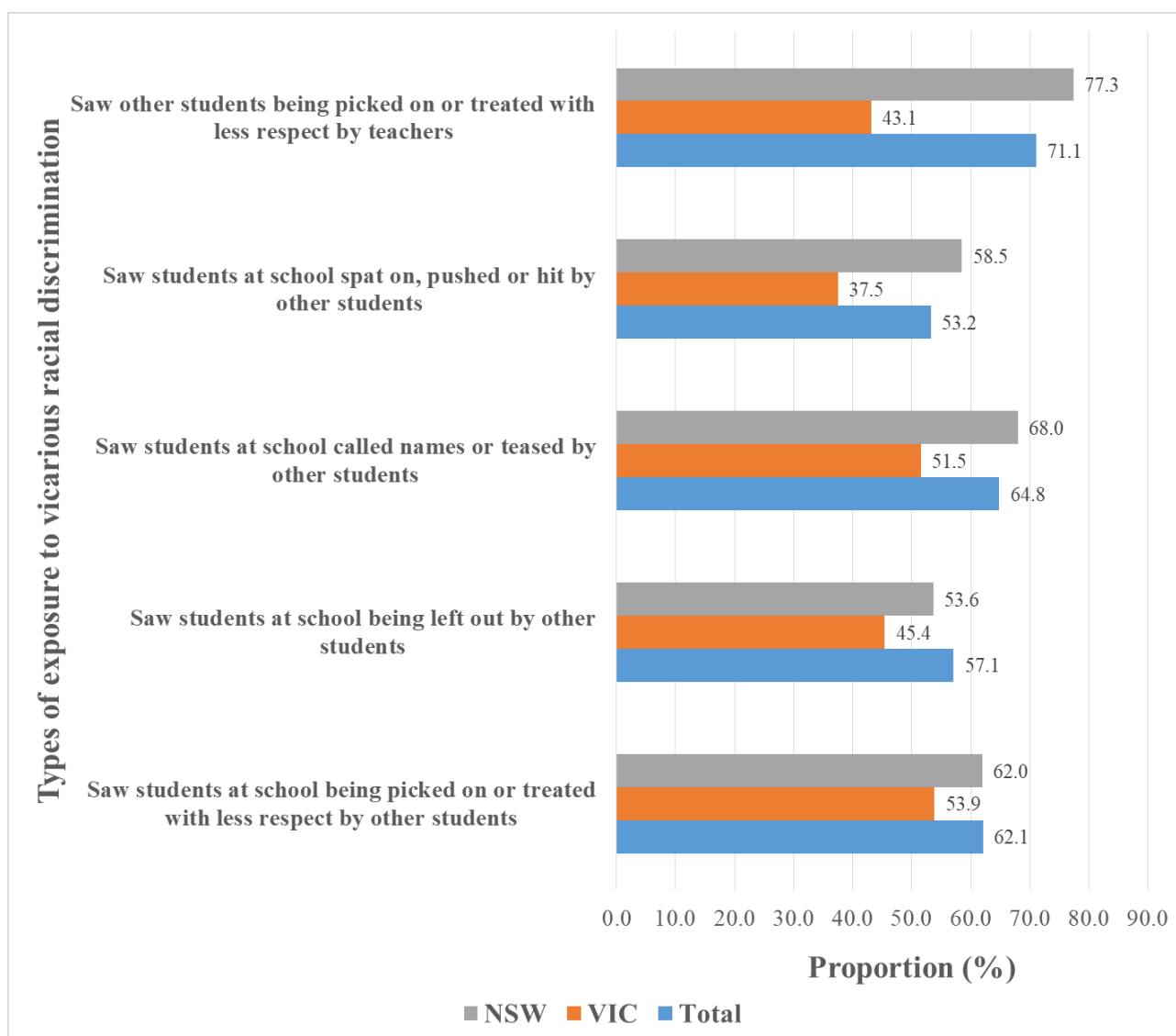


Figure 5.3 Proportion of Pacific/Maori children exposed to vicarious racial discrimination in SOAR by each measurement item

Children from Middle Eastern backgrounds

Among the total SOAR sample, there were 235 children from Middle Eastern backgrounds. 61.3% of children from Middle Eastern backgrounds reported direct experiences of any discrimination (44.9% by peers, 25.3% by teachers and 46.3% in society). 66.4% of children who self-identified as being from a Middle Eastern background reported any vicarious racial discrimination (51.7% by peers and 43.7% by teachers). In Victoria, 69.0% of Middle Eastern children reported experiencing any direct discrimination (51.2% by peers, 21.1% by teachers, and 50.5% in society). 67.0% reported any vicarious racial discrimination (56.6% by peers and 45.6% by teachers) (see Figure 5.4). Figure 5.5 and Figure 5.6 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

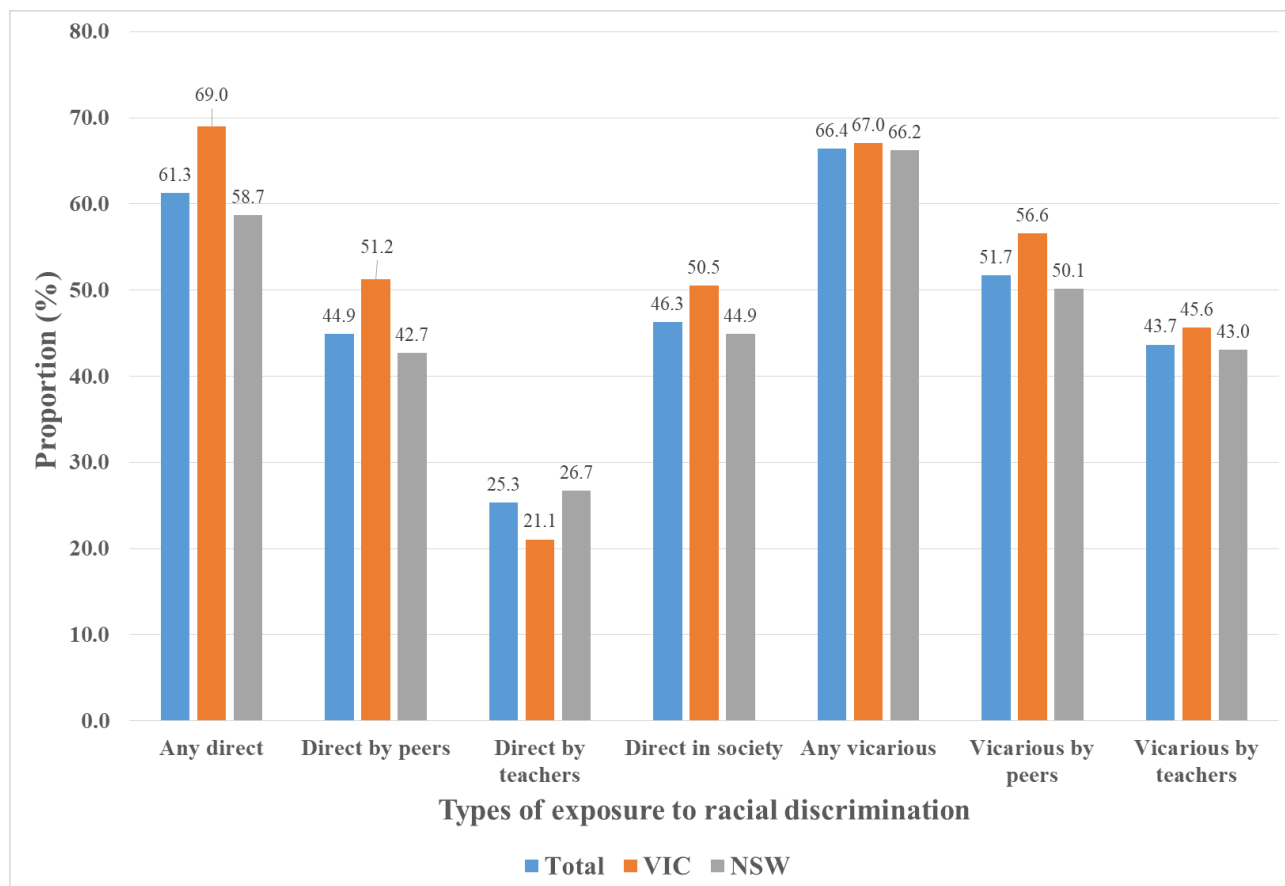


Figure 5.4 Proportion of Middle Eastern children exposed to any racial discrimination in SOAR

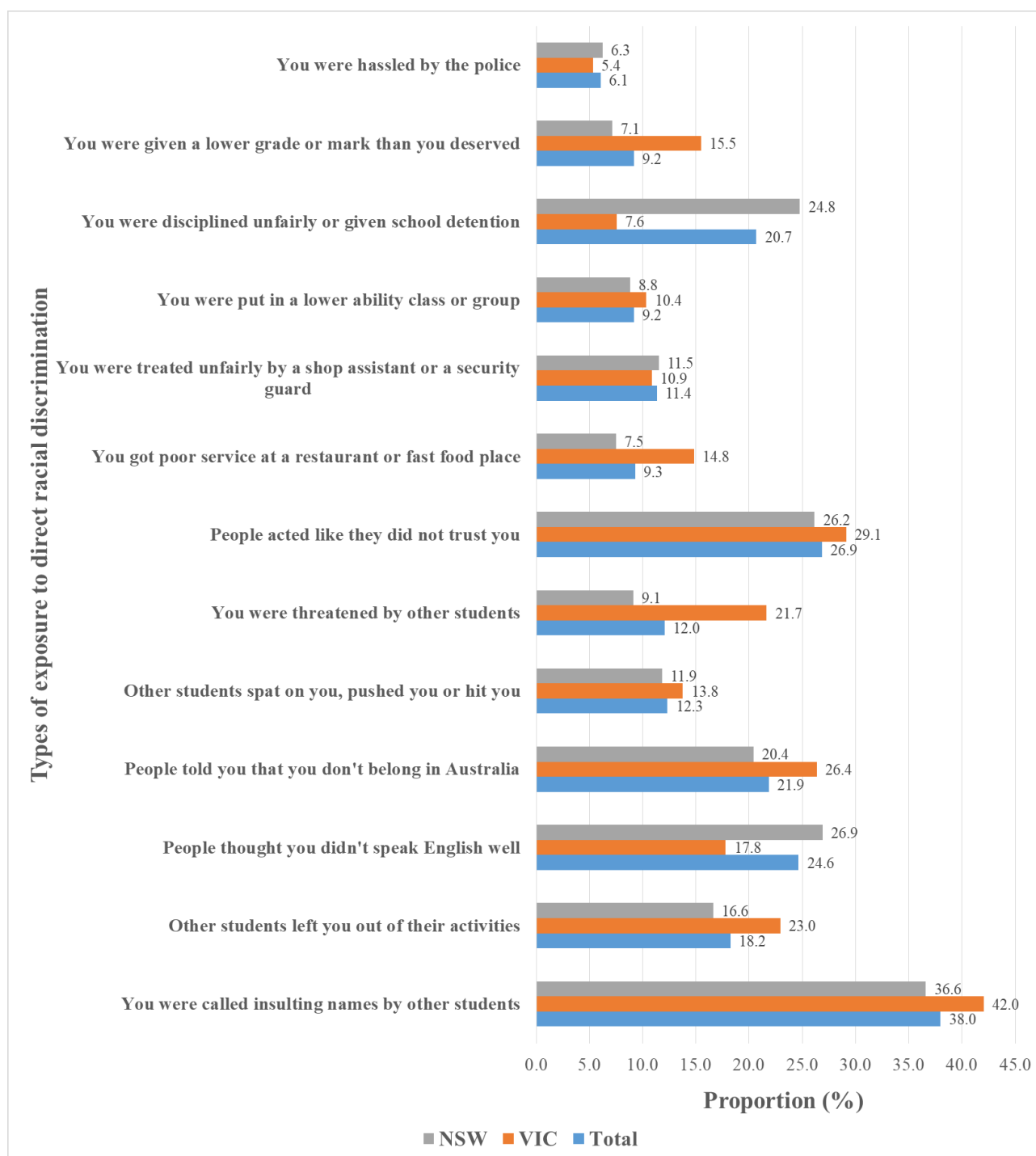


Figure 5.5 Proportion of Middle Eastern children exposed to direct racial discrimination in SOAR by each measurement item

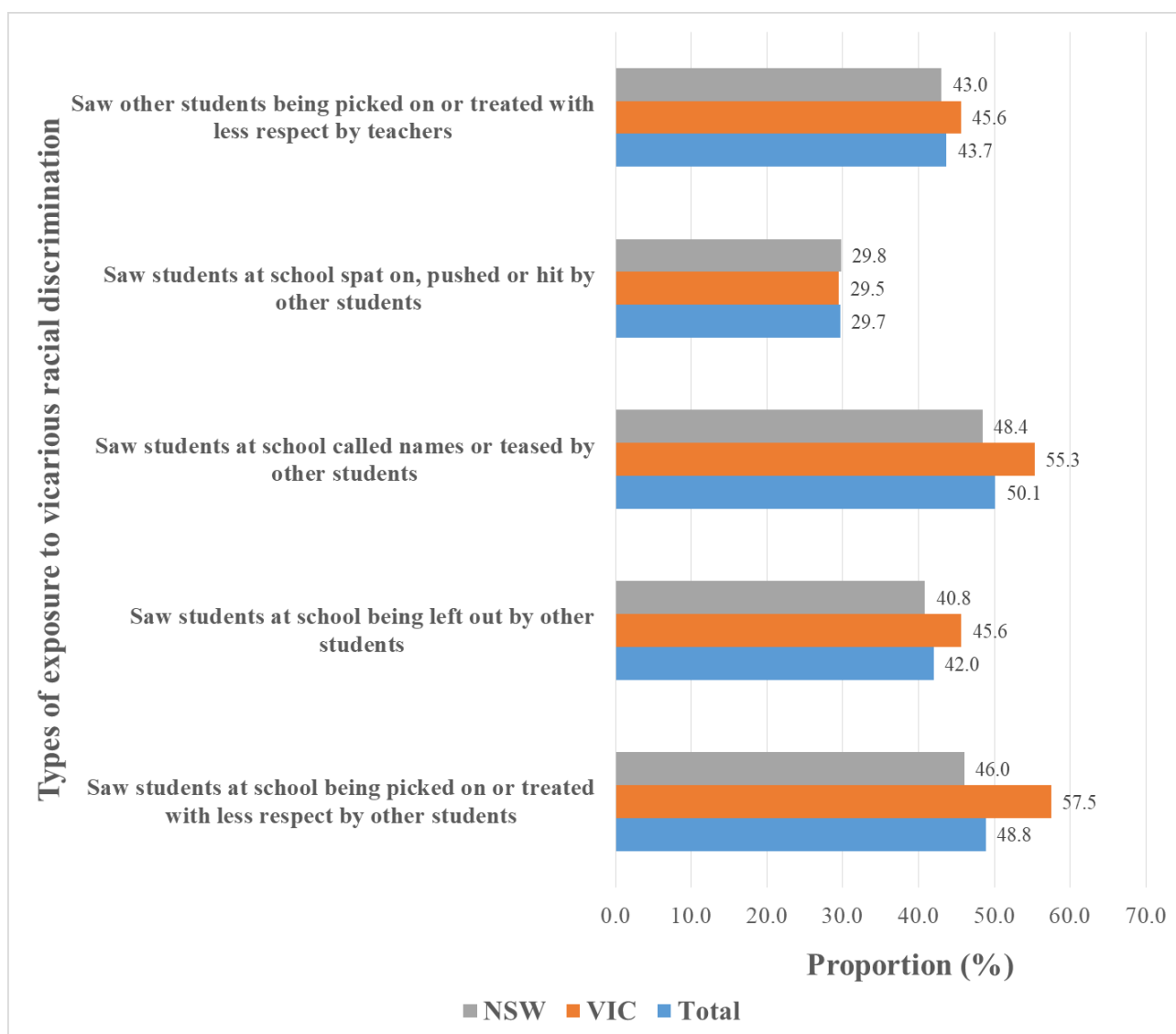


Figure 5.6 Proportion of Middle Eastern children exposed to vicarious racial discrimination in SOAR by each measurement item

Children from African backgrounds

Among the total SOAR sample, there were 159 children from African backgrounds. 58.0% of children from African backgrounds reported direct experiences of any discrimination (49.3% by peers, 31.7% by teachers and 46.4% in society). 82.8% of children who self-identified as being from an African background reported any vicarious racial discrimination (67.5% by peers and 53.5% by teachers). In Victoria, 70.0% of children who identified as being from African backgrounds reported experiencing any direct discrimination (60.2% by peers, 42.3% by teachers, and 50.7% in society). Almost three-quarters (73.6%) reported any vicarious racial discrimination (53.6% by peers and 56.0% by teachers) (see Figure 5.7). Figure 5.8 and Figure 5.9 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

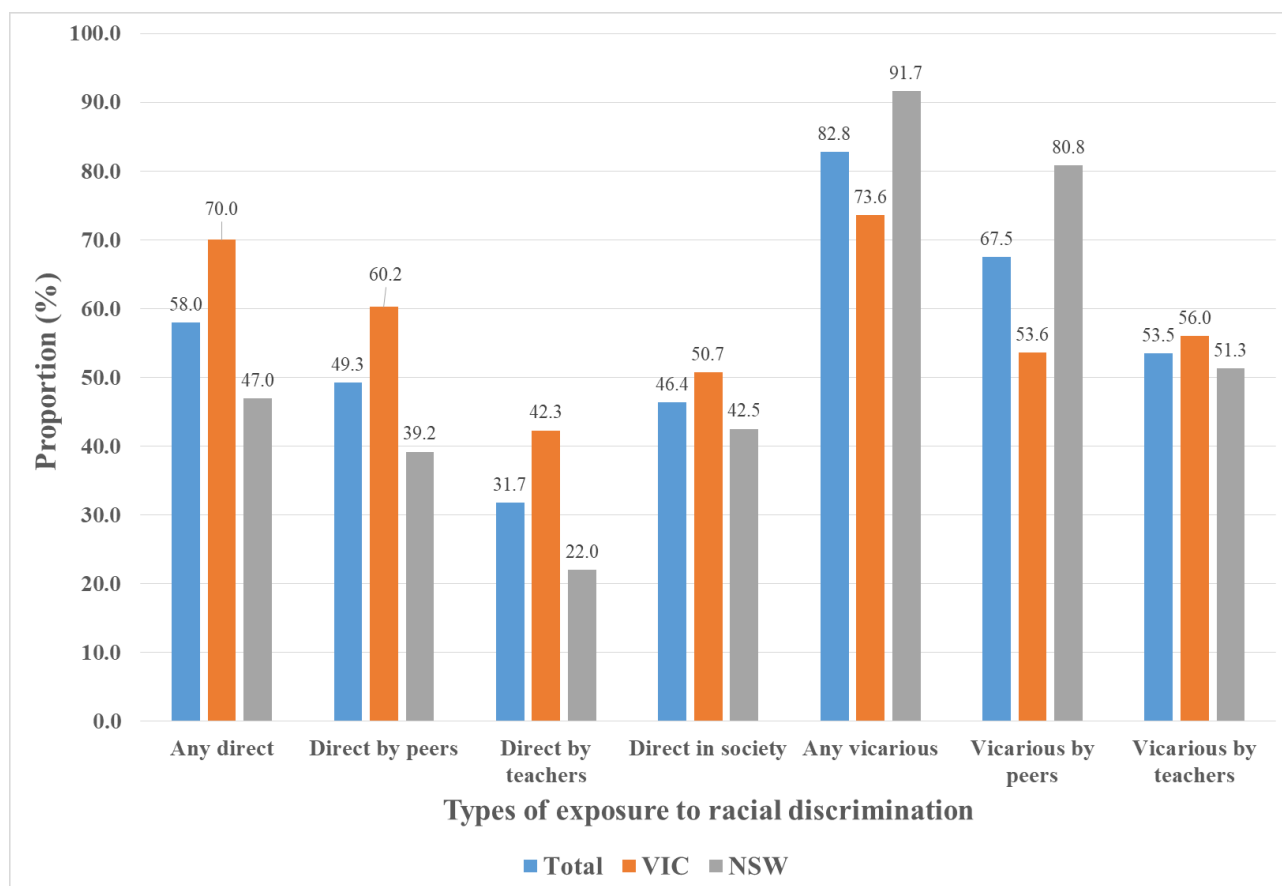


Figure 5.7 Proportion of African children exposed to any racial discrimination in SOAR

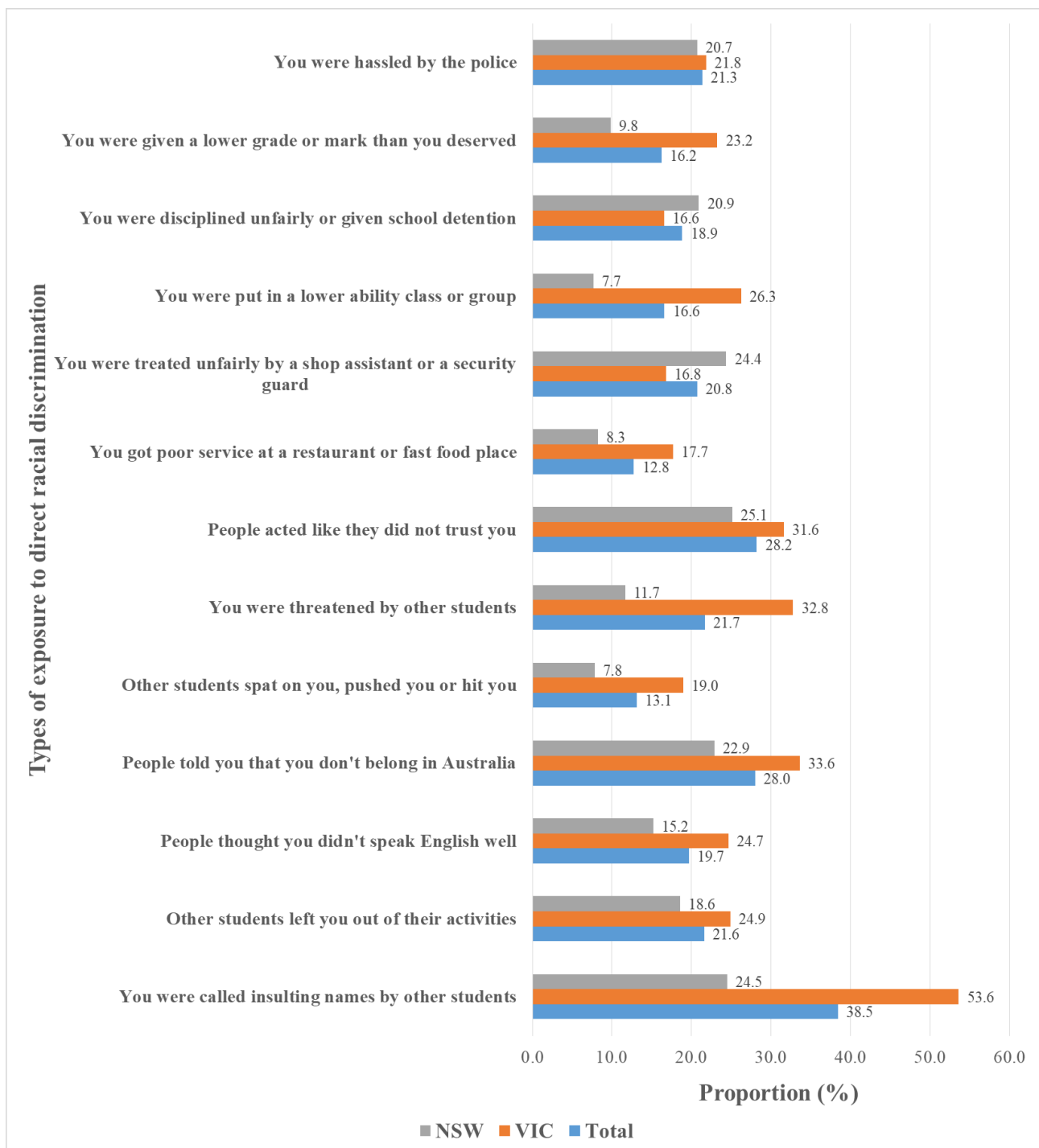


Figure 5.8 Proportion of African children exposed to direct racial discrimination in SOAR by each measurement item

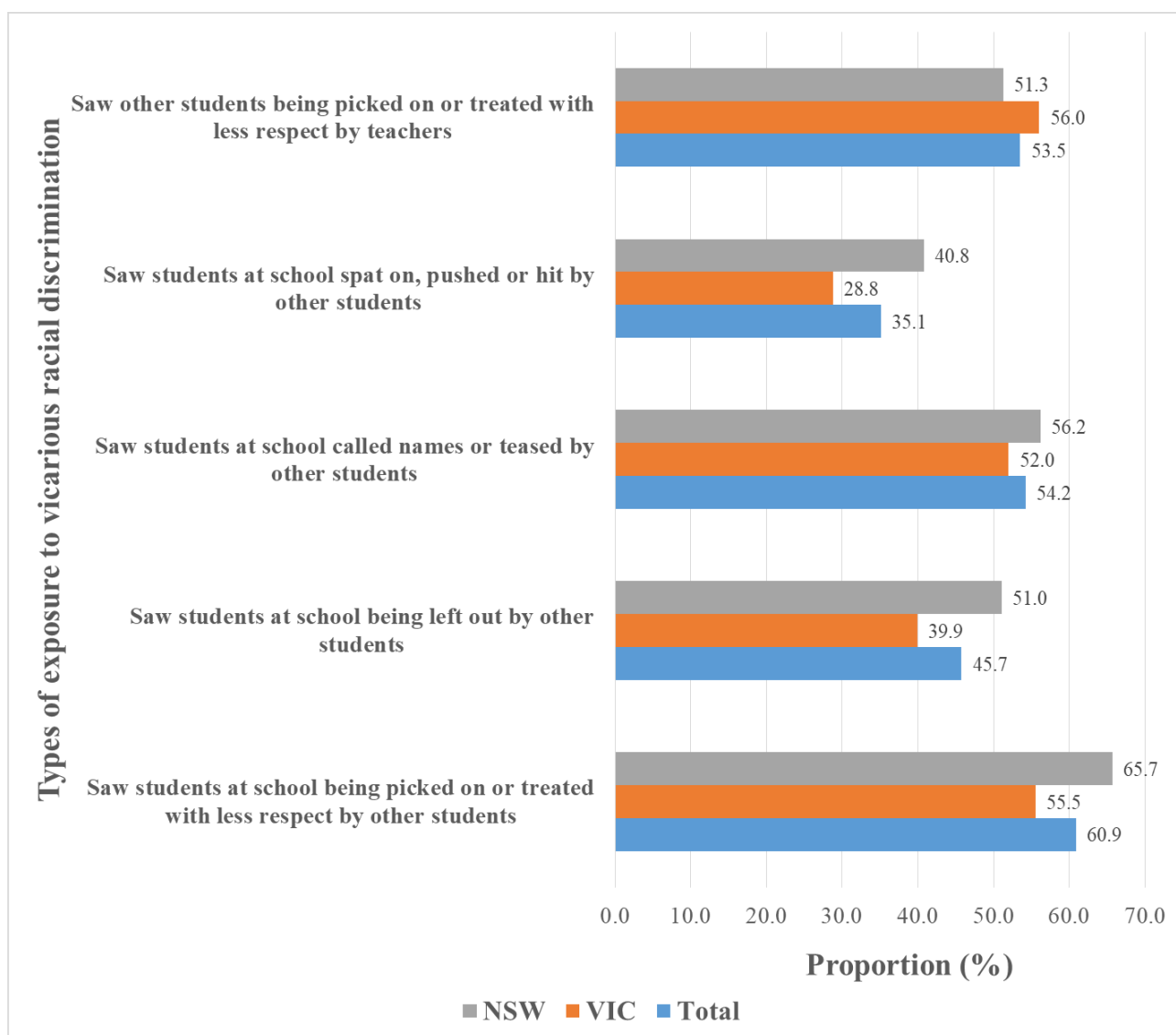


Figure 5.9 Proportion of African children exposed to vicarious racial discrimination in SOAR by each measurement item

Children from South Asian backgrounds

Among the total SOAR sample, there were 279 children from South Asian backgrounds. 61.9% of children from South Asian backgrounds reported direct experiences of any discrimination (45.2% by peers, 21.9% by teachers and 45.7% in society). 82.2% of children who self-identified as being from a South Asian background reported any vicarious racial discrimination (74.4% by peers and 44.0% by teachers). In Victoria, 63.5% of East Asian children reported experiencing any direct discrimination (51.4% by peers, 22.5% by teachers, and 50.0% in society). 75.4% reported any vicarious racial discrimination (68.7% by peers and 42.1% by teachers) (see Figure 5.13). Figure 5.14 and Figure 5.15 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

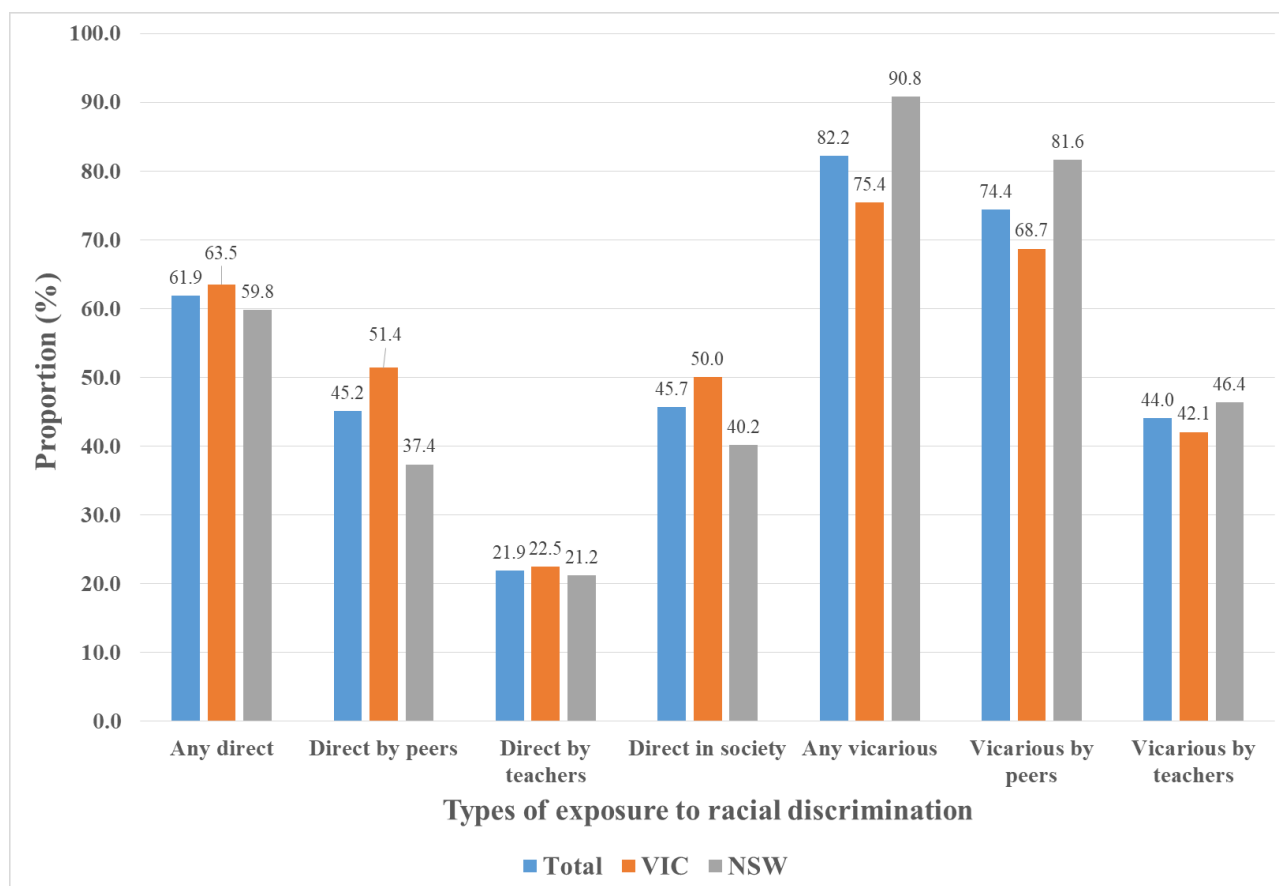


Figure 5.13 Proportion of South Asian children exposed to any racial discrimination in SOAR

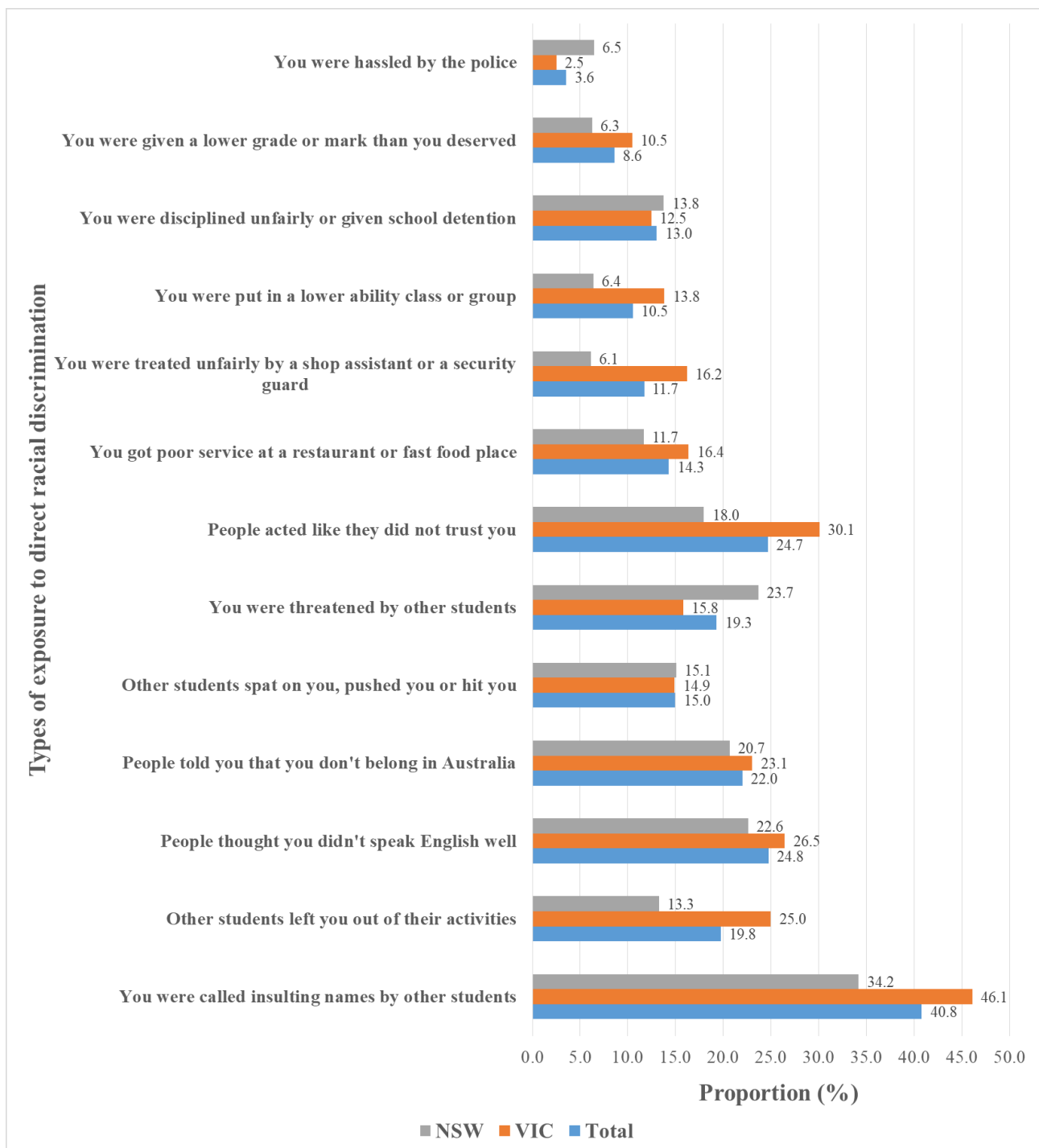


Figure 5.14 Proportion of South Asian children exposed to direct racial discrimination in SOAR by each measurement item

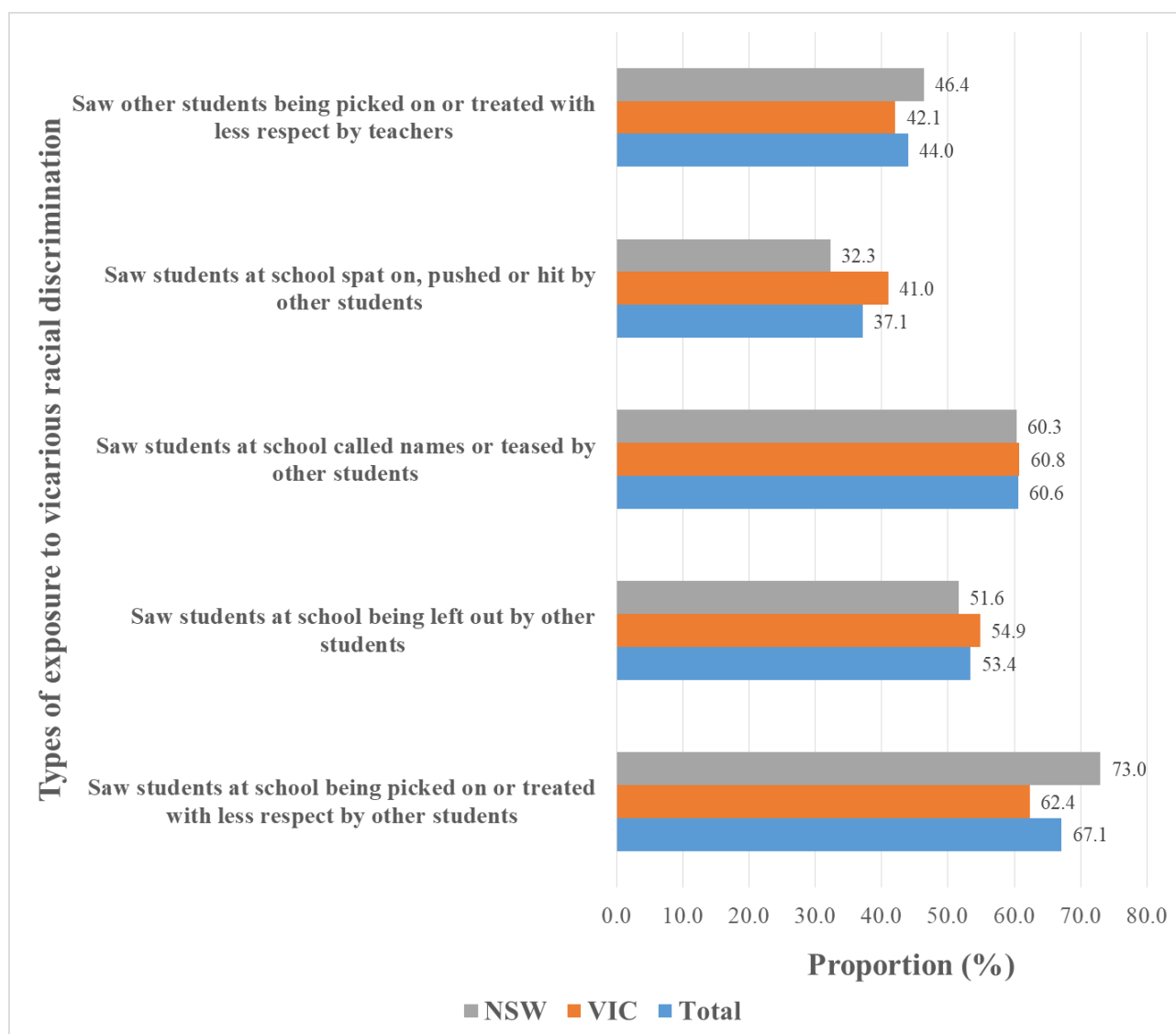


Figure 5.15 Proportion of South Asian children exposed to vicarious racial discrimination in SOAR by each measurement item

Children from East Asian backgrounds

Among the total SOAR sample, there were 325 children from East Asian backgrounds. Just over two-thirds (67.1%) of children from East Asian backgrounds reported direct experiences of any discrimination (47.8% by peers, 18.9% by teachers and 55.0% in society). 69.4% of children who self-identified as being from an East Asian background reported any vicarious racial discrimination (62.9% by peers and 46.0% by teachers). In Victoria, 66.1% of East Asian children reported experiencing any direct discrimination (43.3% by peers, 19.2% by teachers, and 60.0% in society). 78.7% reported any vicarious racial discrimination (68.6% by peers and 44.7% by teachers) (see Figure 5.16). Figure 5.17 and Figure 5.18 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

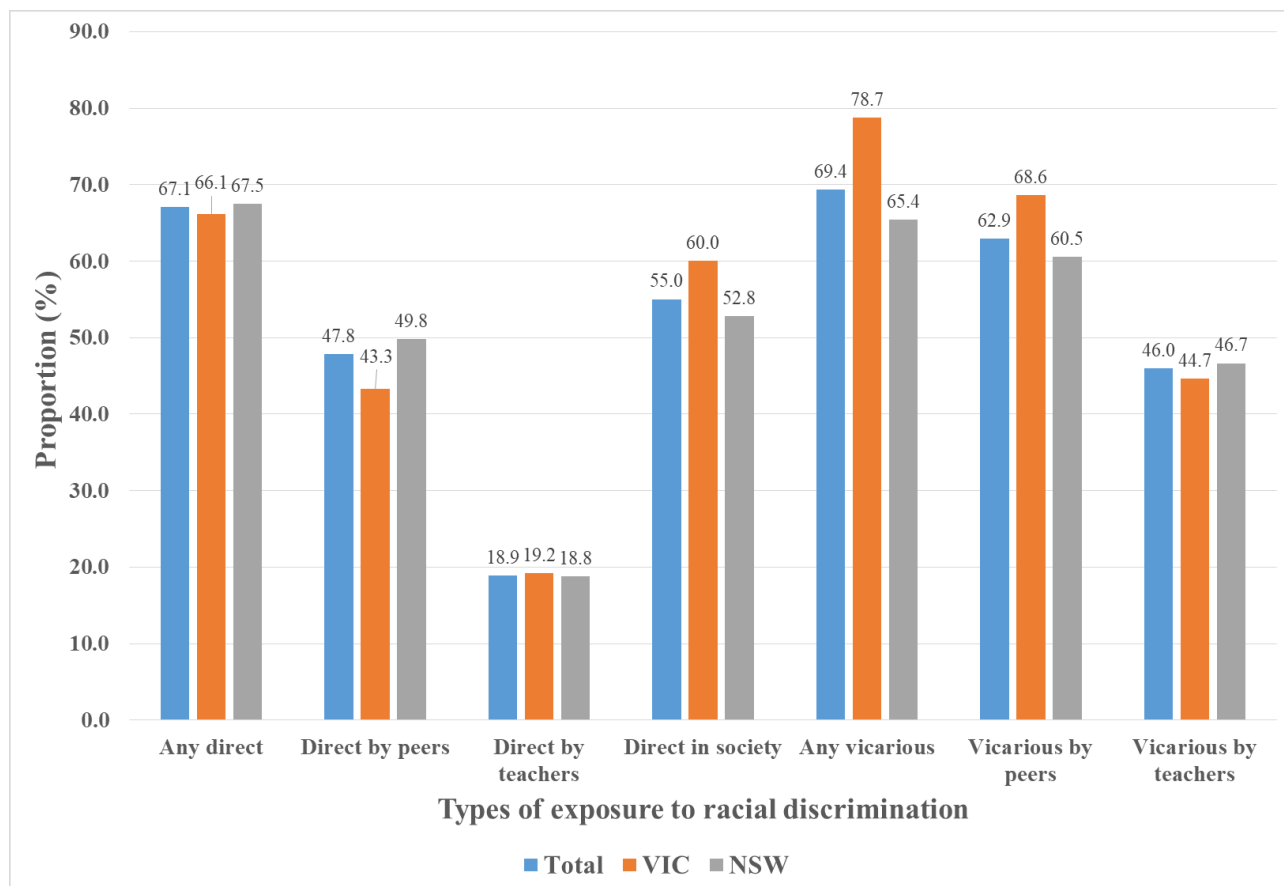


Figure 5.16 Proportion of East Asian children exposed to any racial discrimination in SOAR

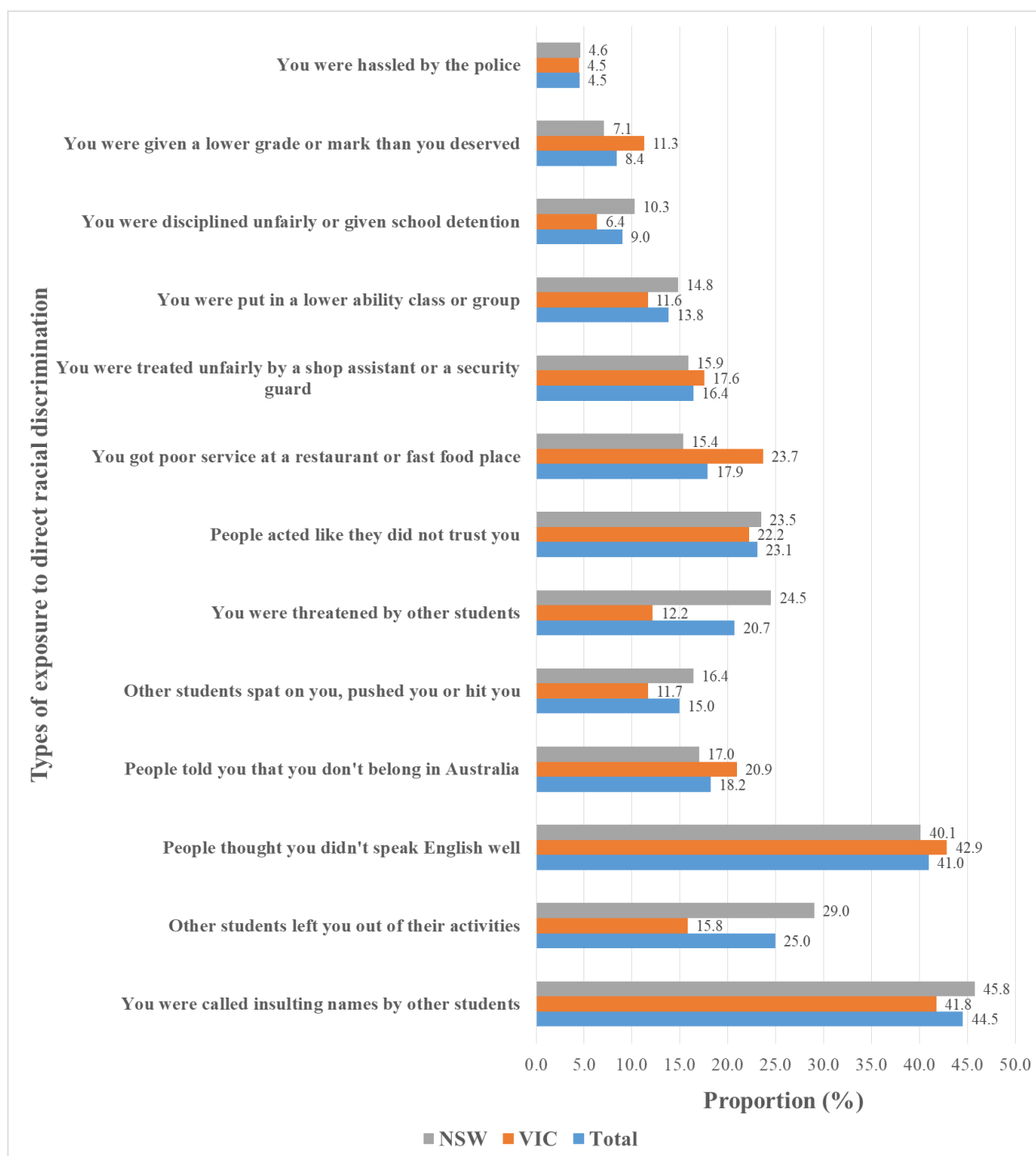


Figure 5.17 Proportion of East Asian children exposed to direct racial discrimination in SOAR by each measurement item

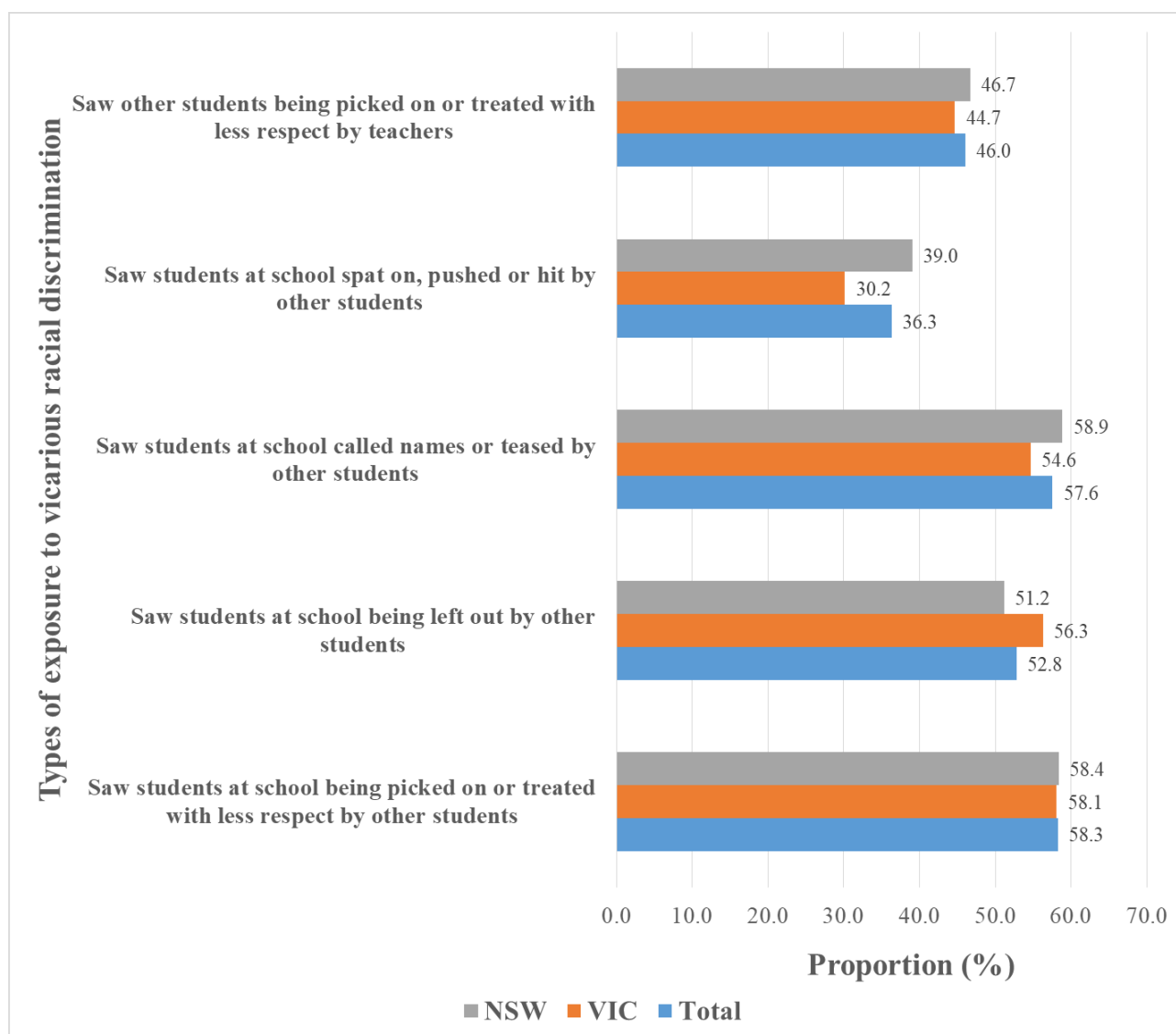


Figure 5.18 Proportion of East Asian children exposed to vicarious racial discrimination in SOAR by each measurement item

Children from Southeast Asian backgrounds

Among the total SOAR sample, there were 360 children from Southeast Asian backgrounds. 58.7% of children from Southeast Asian backgrounds reported direct experiences of any discrimination (45.5% by peers, 20.0% by teachers and 43.6% in society). 67.4% of children who self-identified as being from a Southeast Asian background reported any vicarious racial discrimination (56.1% by peers and 47.7% by teachers). In Victoria, 75.1% of Southeast Asian children reported experiencing any direct discrimination (57.2% by peers, 20.5% by teachers, and 56.9% in society). 75.3% reported any vicarious racial discrimination (73.3% by peers and 47.6% by teachers) (see Figure 5.19). Figure 5.20 and Figure 5.21 show the prevalence of direct and vicarious discrimination by each measure of racial discrimination.

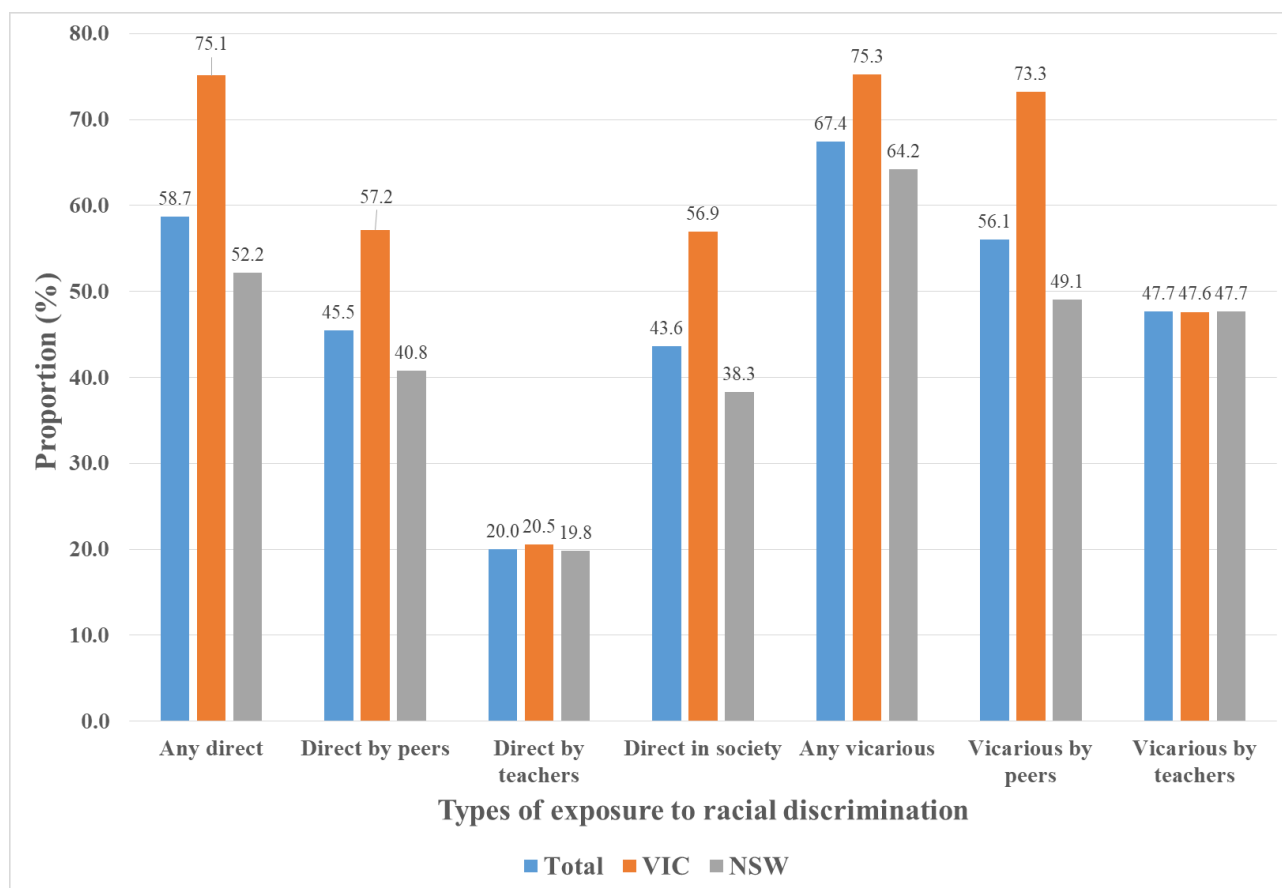


Figure 5.19 Proportion of SE Asian children exposed to any racial discrimination in SOAR

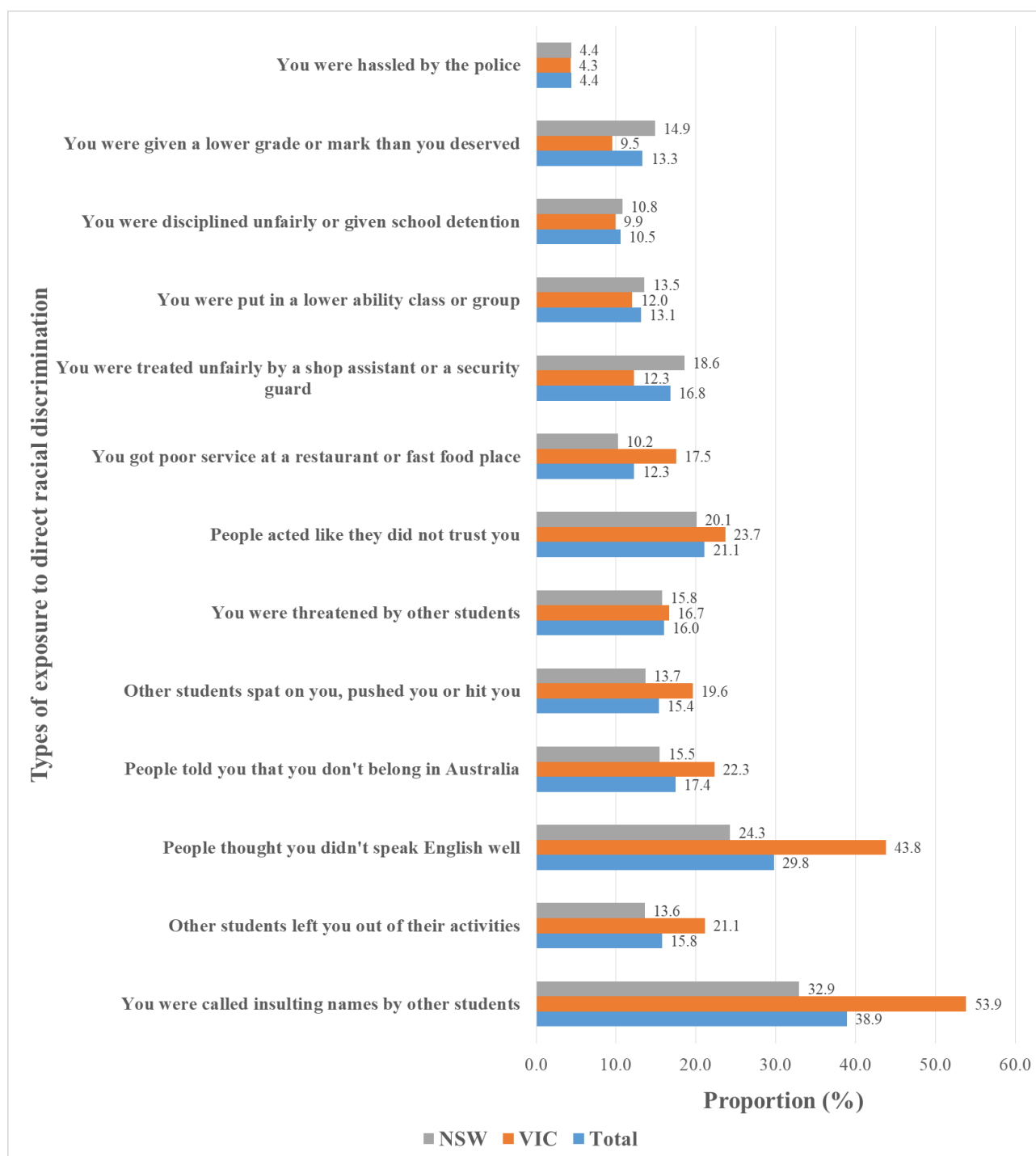


Figure 5.20 Proportion of SE Asian children exposed to direct racial discrimination in SOAR by each measurement item

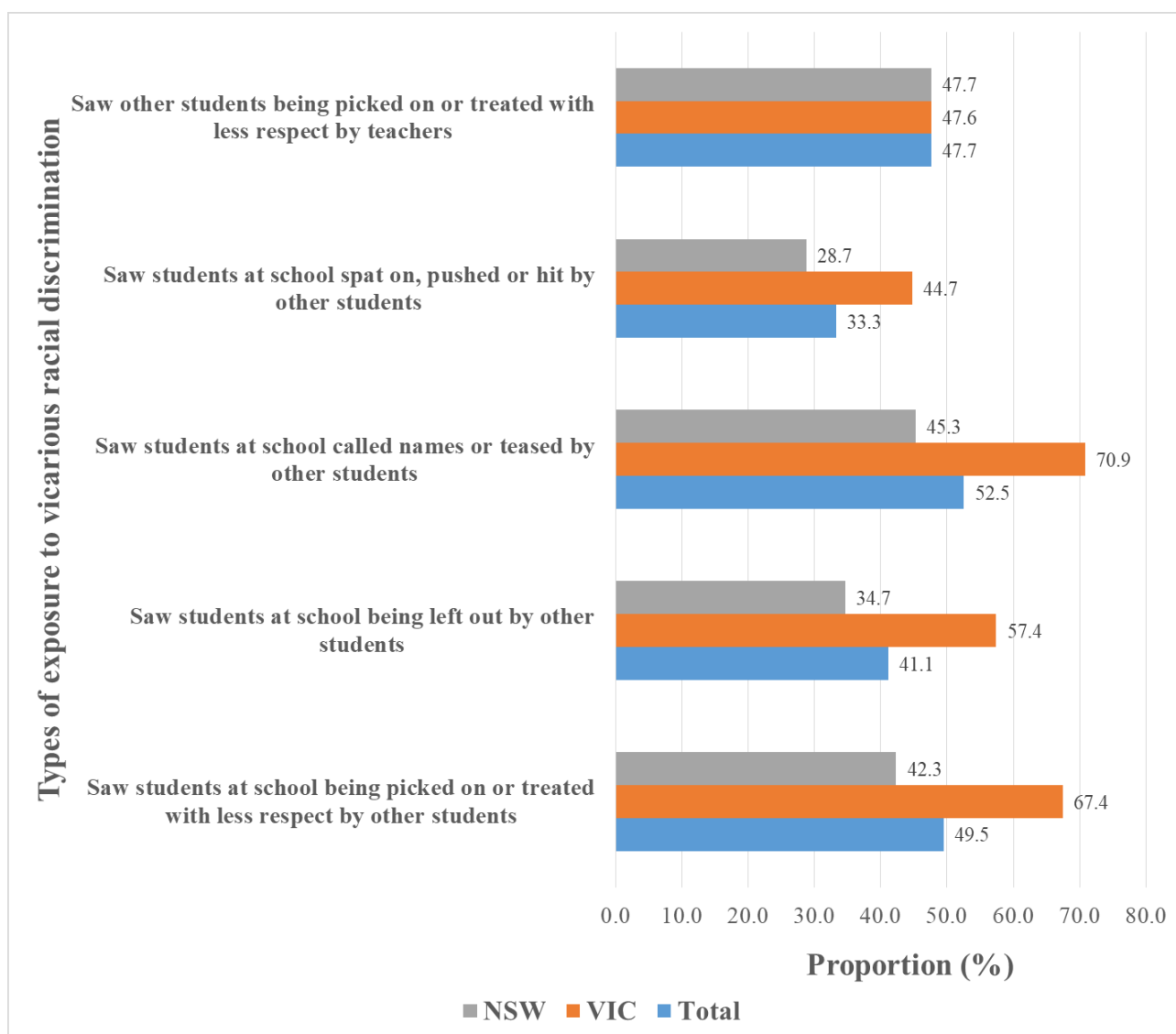


Figure 5.21 Proportion of SE Asian children exposed to vicarious racial discrimination in SOAR by each measurement item

Longitudinal Study of Australian Children (LSAC)

Study overview

LSAC is a nationally representative sample of two cohorts of Australian children – the birth cohort (B-cohort) of 5107 infants, and the kindergarten cohort (K-cohort) of 4983 4-year-olds – each of which commenced in May 2004.¹²² In short, a two-stage clustered design was employed to select a sample that was broadly representative of all Australian children except those living in remote areas. LSAC data has been collected every two years. In both cohorts (B-cohort: Wave 7; K-cohort: Wave 5-7), LSAC includes 3 self-report items of direct experiences of racial discrimination. Wave 7 (2016) is the latest LSAC release available for both cohorts. In the B-cohort, we examined the prevalence of direct racial discrimination when children from visible minority backgrounds were at aged 12-13 years (Wave 7).

Key findings

Results showed that 13.0% of minority children reported direct racial discrimination. As shown in Figure 6.1, children from visible minority backgrounds reported higher levels of racial discrimination if they were boys, from the older age group, living with a primary carer who did not complete Year 12 and living in the non-metropolitan areas (See Appendix 2 for more details).

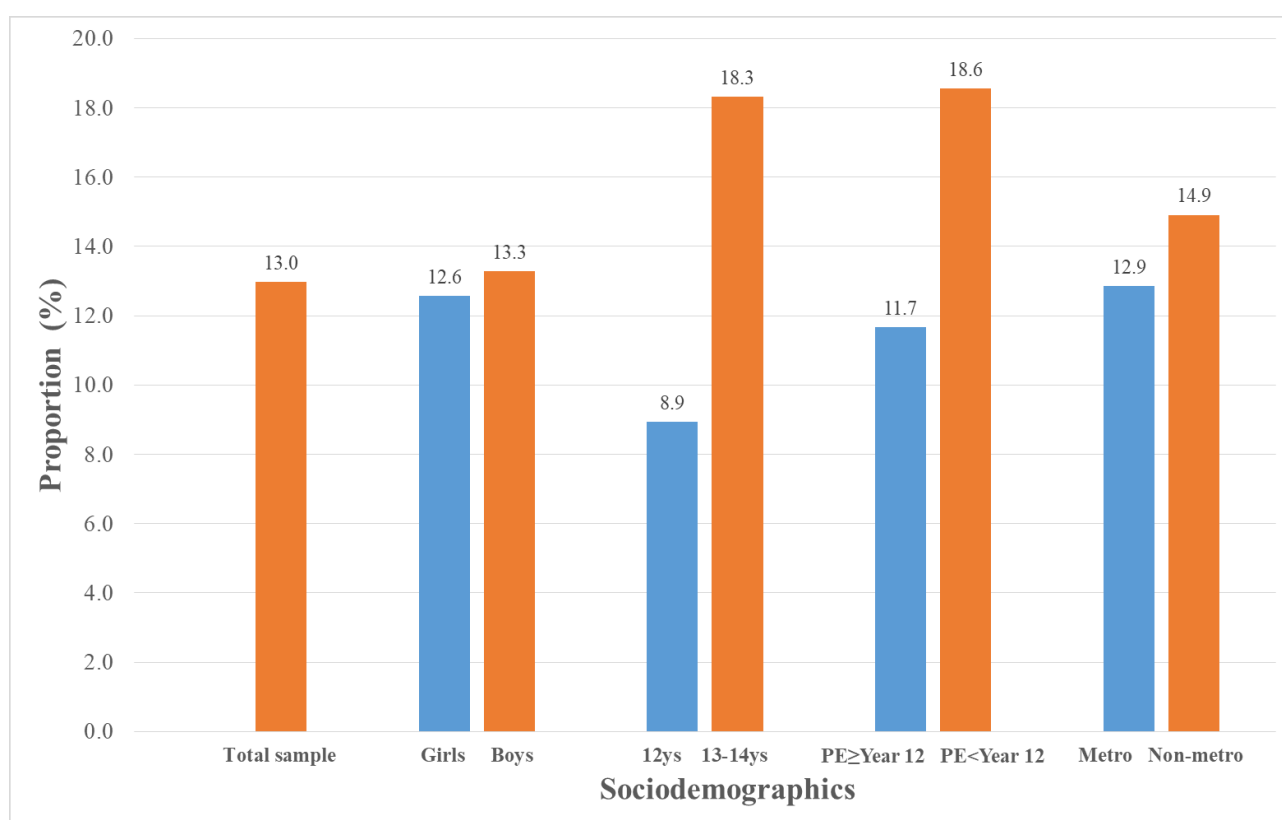


Figure 6.1 Proportion of ethnic minoritised and migrant children and young people exposed to racial discrimination in LSAC B-cohort Wave 7 samples

(Notes: PE refers to Primary carer's highest education level)

In the K-cohort, we also examined the prevalence of direct racial discrimination when children from visible minority backgrounds were at aged 16-17 years (Wave 7). Results showed that 15.9% of those children reported direct racial discrimination. As shown in Figure 6.2, children from visible minority backgrounds reported higher levels of racial discrimination if they were boys, from the older age group, living with a primary carer who did not complete Year 12 and living in the metropolitan areas (See Appendix 2 for more details).

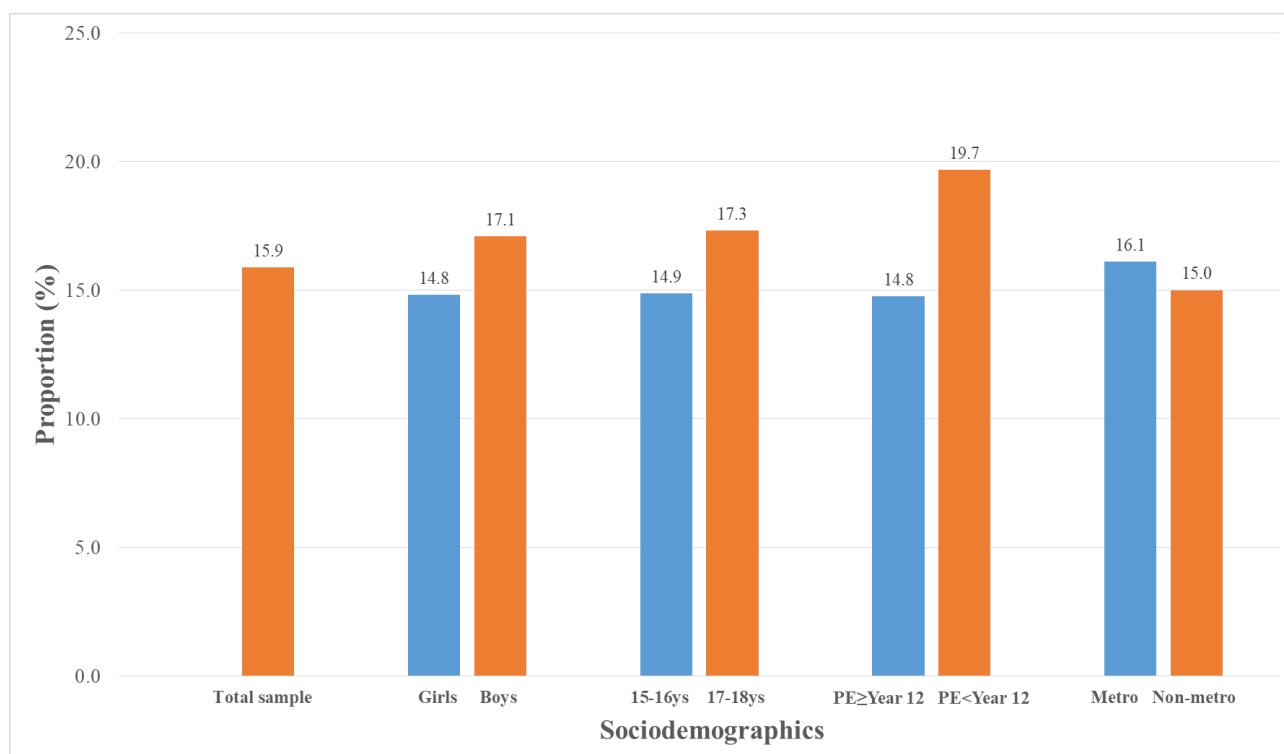


Figure 6.2 Proportion of ethnic minoritised and migrant children and young people exposed to racial discrimination in LSAC K-cohort Wave 7 samples

(Notes: PE refers to Primary carer's highest education level)

Hidden Costs: Young Multicultural Victorians and coronavirus

Study overview

In June 2020, the Centre for Multicultural Youth (CMY) conducted a rapid response survey 'Racism during COVID-19'. Participants aged 15-26 who live, work and play in Victoria were asked to participate in the survey. Of the 371 participants, 162 (46%) self-identified their racial, ethnic or cultural background as being from a multicultural background (non-Anglo or European, Not Aboriginal).

Key findings

In this survey, participants were asked about their experiences of direct and vicarious racism and/or discrimination. They also reported impact of racism on their social behaviour using a hypervigilance scale and about worry about racism in returning to their everyday lives post coronavirus restrictions. In the total sample of 371 participants aged 15-26, 85.0% of participants who self-identified as being from a multicultural background had at least one experience of direct racism and/or discrimination, 73.5% in the community/society; 44.3% in school/work; and 65.5% from peers. 92.3% of participants had at least one experience of vicarious discrimination since the start of the coronavirus. 93.0% of participants consciously adjusting their behaviour in public to reduce their exposure to racism. 87.0% of participants reported being worried to return to their everyday lives and public spaces after lockdown, for fear of experiencing racial discrimination.

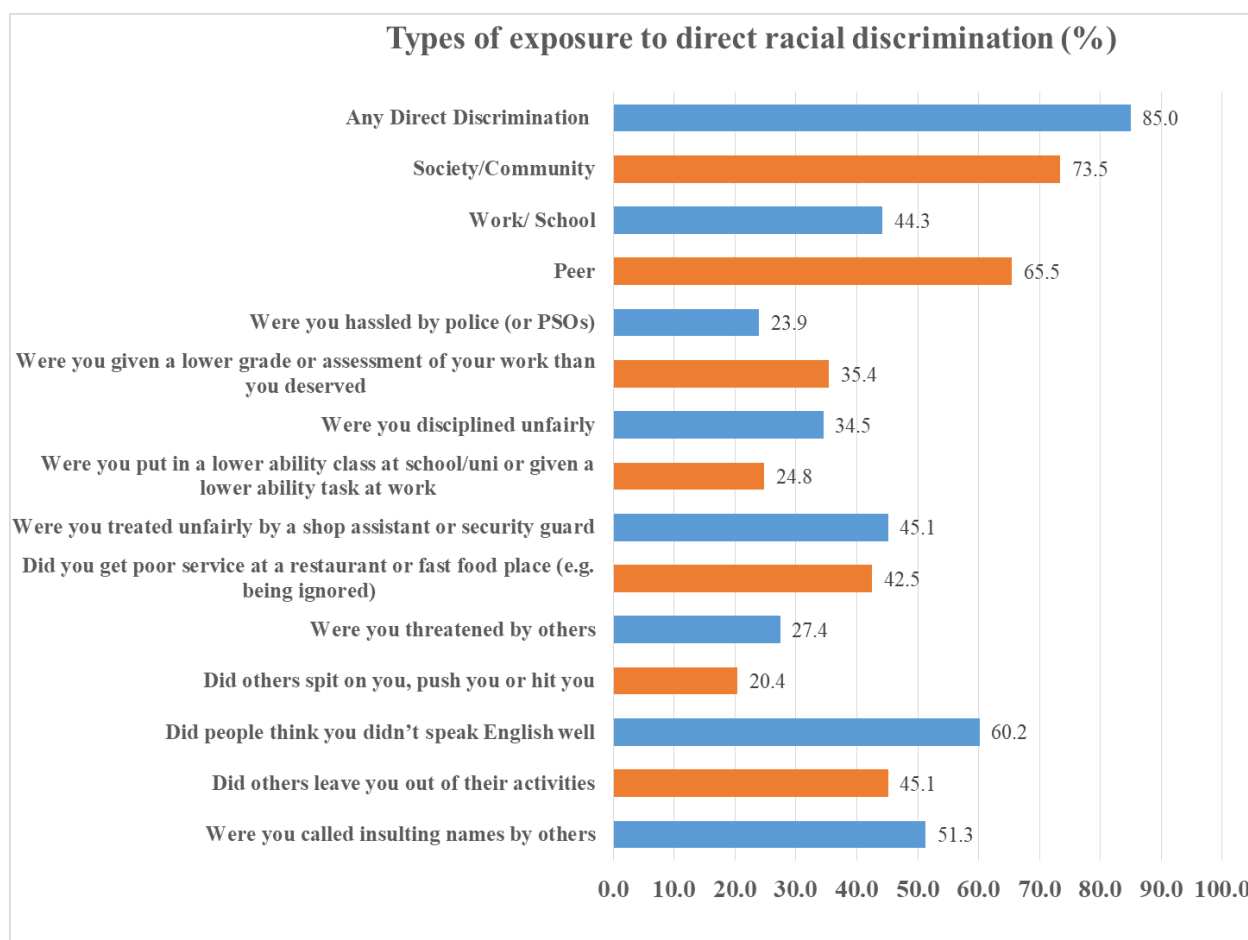


Figure 7.1 Proportion of children and young people exposed to direct racial discrimination in CMY

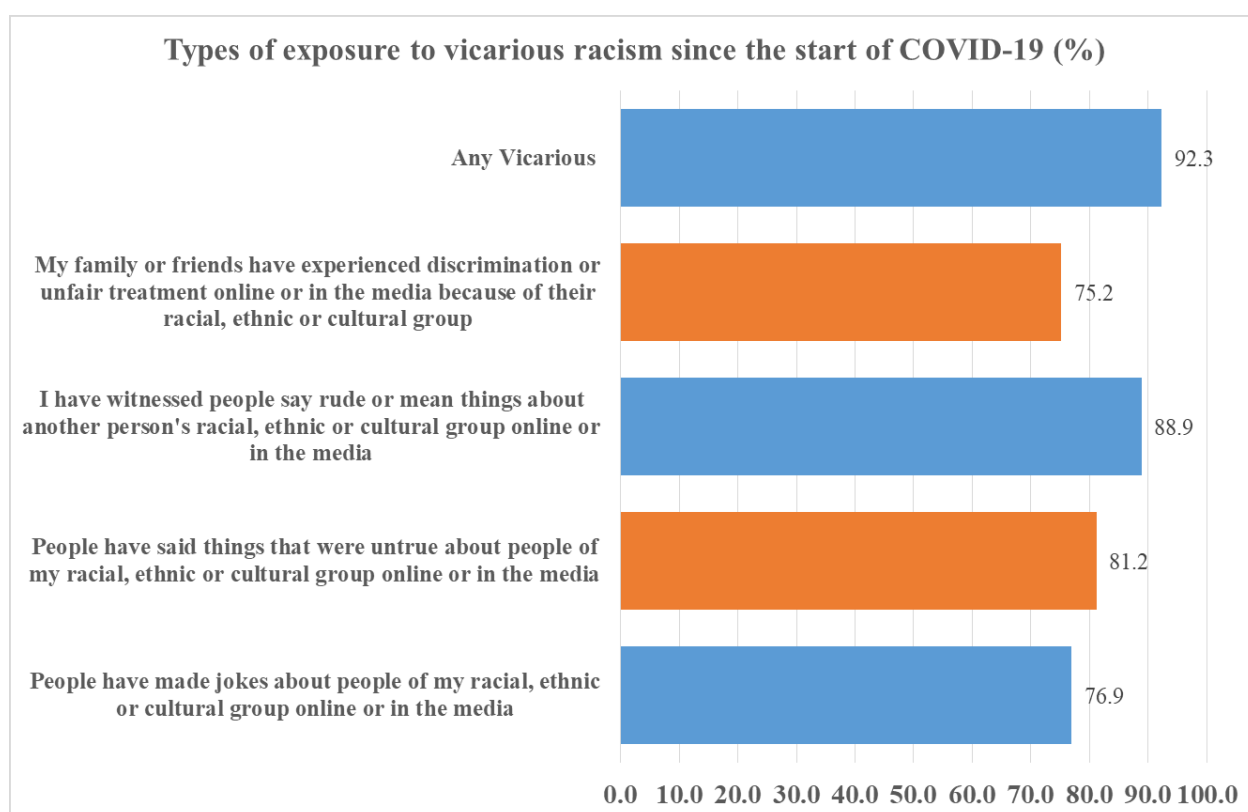


Figure 7.2 Proportion of children and young people exposed to vicarious racial discrimination in CMY

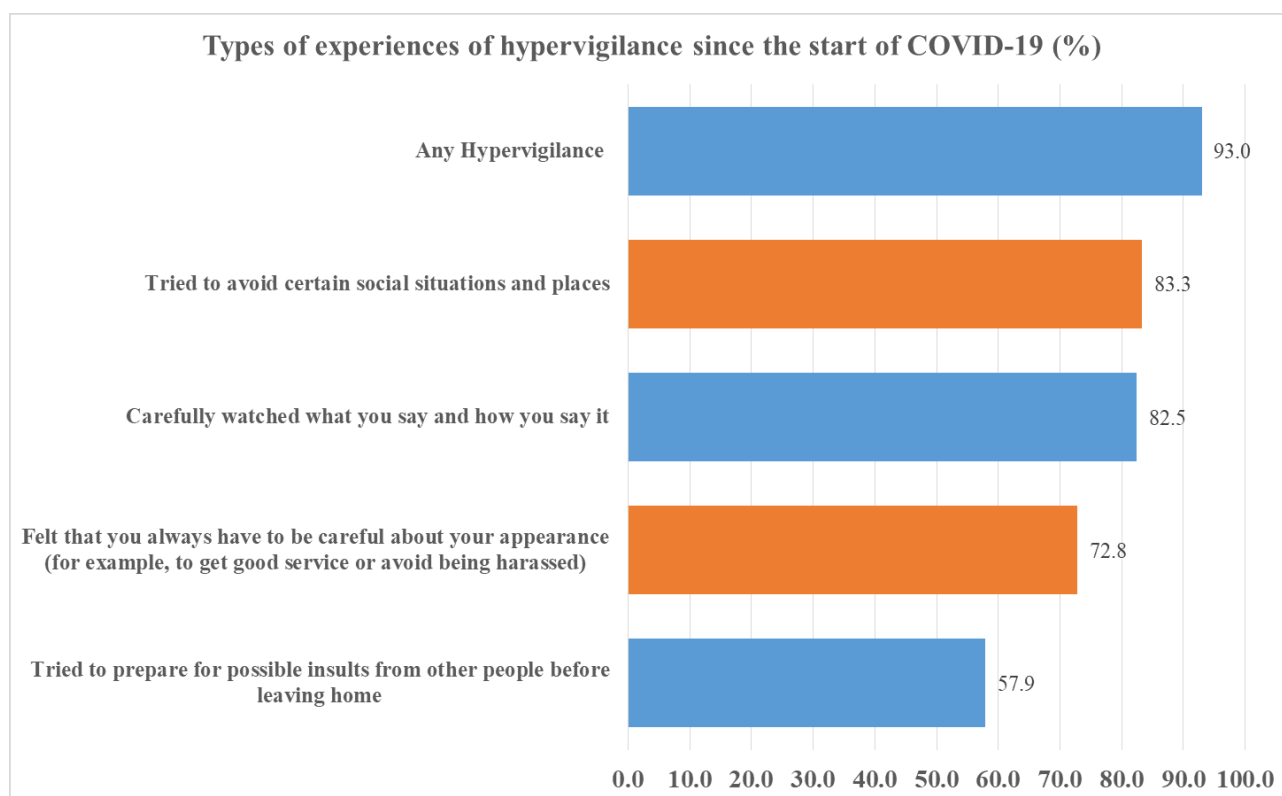


Figure 7.3 Proportion of children and young people exposed to hypervigilance in CMY

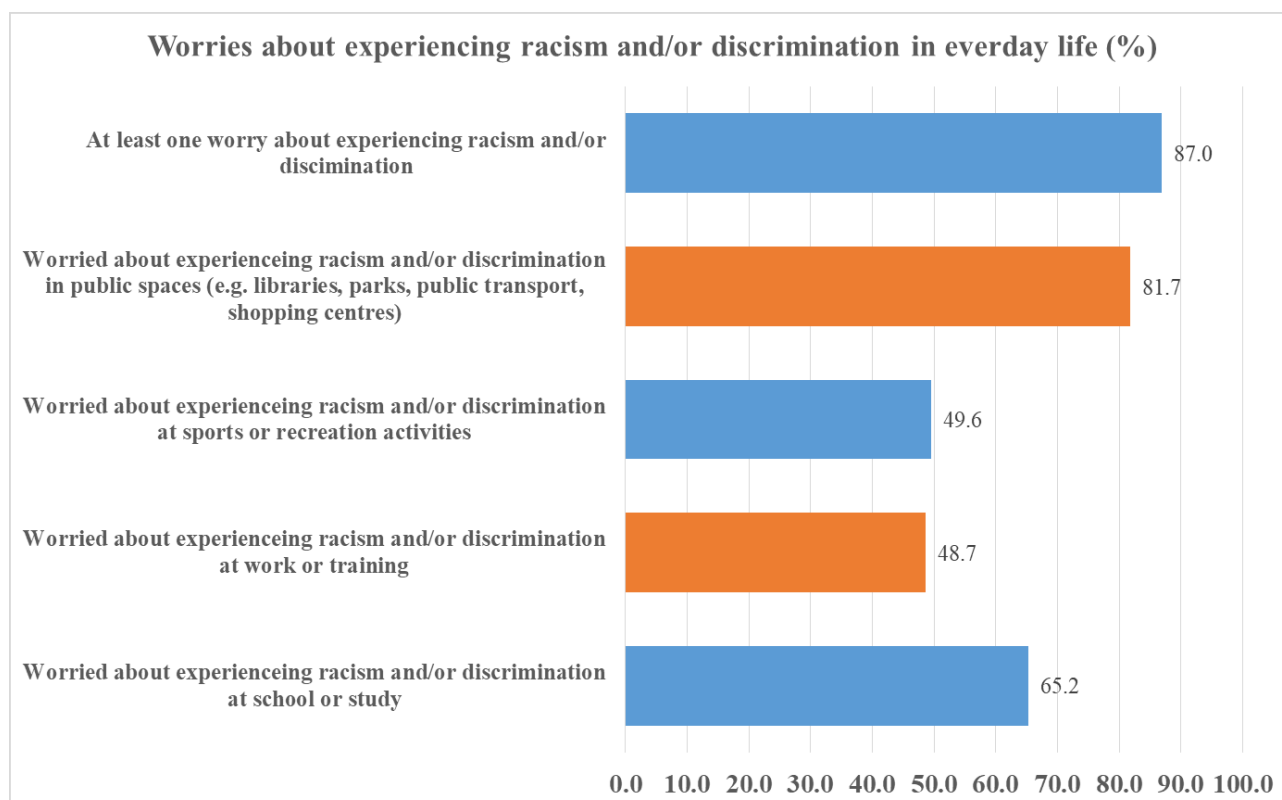


Figure 7.4 Proportion of children and young people who had worries about experiencing racism and/or discrimination in everyday life in CMY

Swimming with Sandbags – UNICEF

Study overview

Between 9 July and 4 August, UNICEF Australia engaged with YouGov Galaxy to conduct a second nationally representative survey of 1289 children aged 13-17 years to understand and track young people's lived experience of living through the coronavirus pandemic during 2020.¹²³ To better understand the impact of returning to lockdown for young people, Victoria was over-sampled with 403 respondents, with 350 being in Melbourne to gain insight into their particular situation.

Key findings

14% of all children and young people aged 13-17 years had concerns about racial discrimination and racial inequality (see Figure 7.5). Across the country, children and young people living in Victoria (16%) had the highest levels of concerns about racial discrimination, compared to those living in New South Wales (13%) and Queensland (15%).

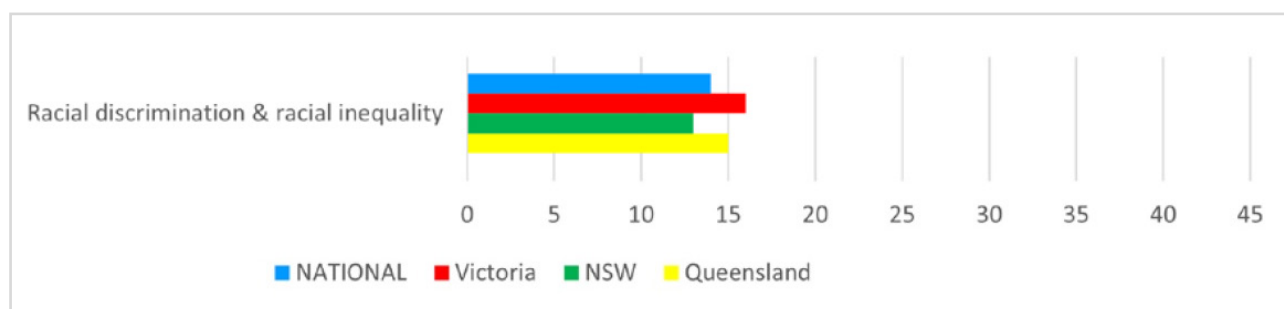


Figure 7.5 Proportion of children and young people who had concerns about racial discrimination & racial inequality in UNICEF

Summary, data gaps, recommendations

Self-reported racial discrimination data among children and young people is increasingly being collected, though progress remains slow. There remains a lack of large-scale prevalence data on self-reported racial discrimination throughout childhood, adolescence and into young adulthood among Aboriginal and Torres Strait Islander populations. Even less data is available for ethnic minoritised children and young people, with only one cross-sectional study including sufficient numbers to allow disaggregation by ethnicity beyond a very broad, heterogeneous group. This is needed across key settings in which children and youth live, grow, learn and play, and across direct and vicarious experiences both in person and online.

While new data collections are a major priority, both to document the nature, prevalence and impact of racism throughout childhood, adolescence and into young adulthood, there is also high need to analyse existing data from the datasets included in this report. This includes detailed exploration of the prevalence of racial discrimination across key sociodemographic characteristics, and settings, associated health impacts, and processes and pathways by which such health impacts occur including identification of key moderating and mediating factors. Quantification of the contribution of self-reported racism to inequities in child and youth health is also a research priority that could be addressed using existing data.

A two fold approach whereby new large-scale data is collected to quantify and capture children and young people's contemporary experiences of racial discrimination in the current coronavirus context, together with analysis of existing large scale and longitudinal data, is recommended to inform targeting of future action across policy, research and practice.

Evidence for addressing racism among 5-25 year olds

Concepts and frameworks for anti-racism and for addressing racism and discrimination among children and young people

The focus of this section of the report is on reducing racism and racial discrimination in the lives of 5-25 year olds by addressing factors that contribute to the occurrence, persistence and endurance of racism and racial discrimination. It primarily focuses on addressing racism within the whole community and reorienting systems, policies, procedures, cultures, attitudes and behaviours – that is strategies that aim to counter and prevent systemic, interpersonal and intrapersonal racism. Efforts to deal with the impacts of racism and racial discrimination of course, continue to be critically important. Racism and racial discrimination affecting particular populations, most notably Aboriginal and Torres Strait Islander children and young people, and children and young people from migrant and ethnic minoritised backgrounds, remain of high concern. Initiatives such as complaints handling systems and raising awareness about how to seek justice when experiencing racism, appropriate counselling and support services for dealing with racism and its effects are all essential. However, while such efforts are vital, they ultimately will not address racism at its core.

Aboriginal and Torres Strait Islander sovereignty foregrounded, Nothing about us without us

As with all processes of health policy formation and implementation, Aboriginal and Torres Strait Islander sovereignty must be foregrounded in all anti-racism action with Aboriginal and Torres Strait Islander peoples, services and communities engaged as leaders and their strength, capability and humanity made visible.⁶⁷

Anti-racism action that is specifically directed at addressing racism towards migrant and minoritised ethnic groups must also engage with those peoples, services and communities.

Children and young people's voices also need to be foundational across all processes of formation and implementation.

Address racism explicitly at a systemic, institutional level – Too often interventions focus on addressing disadvantage and not on the racism that creates, maintains and justifies that state of disadvantage

Race and racism fundamentally shape the way our world and society are structured.⁴⁰ Racism and health inequalities will not ultimately be redressed by a focus on those who experience racism as the site of intervention. Doing so not only draws critical attention away from societal, structural issues and it runs a risk of perpetuating deficit views that frame Aboriginal and Torres Strait Islander peoples, and people from minoritised backgrounds, as having inherent incapacities that require strengthening.⁴⁰

Anti-racism has been broadly defined as 'forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism'^{124 p.4} and as 'ideologies and practices that affirm and seek to enable the equality of races and ethnic groups'.^{125,126} As highlighted above, differentiating between anti-racism and addressing disadvantage is essential. Actions to tackle racism and to address disadvantage are related yet distinct and require different policies and practices. Addressing disadvantage remains critical, and focusing on health and social and economic participation is crucial in directly mitigating further disadvantage resulting from colonisation and migration experiences. However, while policies and practices to address disadvantage may also serve to address a form of indirect racism, they are not able in and of themselves to combat direct forms of racism. Too often interventions, including at policy and community levels, are geared toward alleviating disadvantage and overlook the racism that creates, maintains and justifies that state of disadvantage.¹²⁵ Addressing direct racism (whether systemic, institutional, interpersonal or internalised) requires a specific policy focus on the broader systemic and institutional structures that reproduce racism.¹²⁵

Multi-level, multi-strategy interventions

Multi-level, multi-strategy anti-racism interventions are considered most effective at producing meaningful, lasting reductions in racism as well as other forms of structural stigma.¹²⁷⁻¹²⁹ However, such programs still are rarely implemented with existing interventions largely targeting one level of analysis.¹¹⁴ Moreover, many programs targeting one level of action rely on only one mode of intervention rather than combining multiple approaches e.g. training in empathy and perspective taking with promotion of dual identity. More comprehensive approaches that combine multiple theories, methods, contents and outcome assessments using rigorous methods are still an area of outstanding work, particularly among children and adolescents.¹³⁰

Life-course appropriate

Anti-racism action needs to be appropriate to the developmental needs of children and adolescents and matched to their social, emotional, cognitive and developmental skills. Effective programs require explicit founding in developmental theories and current evidence regarding the development of prejudice and inter-groups relations throughout childhood and adolescence, as well as into adulthood. Too often this is not clear or included within anti-racism programs targeting children and young people, which increases potential for doing harm and of reinforcing rather than countering prejudice and stereotypes.

Understanding how prejudice and intergroup attitudes develop, the extent to which they remain stable throughout childhood and adolescence, and which thresholds of these are key risk factors for negative behaviours, is needed. Exploring such questions using longitudinal designs with close links to prevention and intervention programs is needed to make intervention programs more effective.

Rigorously evaluated, including adherence to the principle of ‘do no harm’

While anti-racism programs have many potential benefits for population health equity and for children, young people and their families, such programs also have risks and can do harm if poorly designed and implemented.^{131,132} Specific potential harms to children and adolescents include heightened negative emotions including anger, distress and anxiety among those who are targets of racism, guilt and defensiveness among non-stigmatised groups, and increased stereotyping and bias and mistrust of other groups.¹³¹ It is imperative that before implementation programs undergo high quality effectiveness evaluations to ensure interventions do no harm and do not perpetuate the very issues they are intending to address.¹³³ As noted above, ensuring programs explicitly articulate the developmental theories and evidence regarding the development of prejudice and inter-groups relations on which they are based, even prior to initial feasibility studies is essential.¹³³ This is a major issue for the field, where often good intentions prevail over evidence-based approaches.

The policy frameworks identified in previous sections, including the National Aboriginal and Torres Strait Islander Health Plan,³⁰ the national multicultural statement,³¹ the Victorian Aboriginal Affairs Framework,³² Balit Murrup: Aboriginal social and emotional wellbeing framework,³⁴ and the Victorian Aboriginal and Local Government Action Plan,³³ all provide a support, context and guidance for these anti-racism priorities just described. The Productivity Commission’s Indigenous Evaluation Framework also provides practical guidance on ensuring Aboriginal and Torres Strait Islander people are central in decision-making and policy and practice evaluation.³⁵ This includes action on racism.

Evidence of effective and promising anti-racism approaches

Structural, systemic, institutional anti-racism

Race and racism profoundly shape the structures, systems and institutions of society. Racism itself is systemic, with reciprocal reinforcement across systems and between individual and systemic levels.^{134,135} Above we highlighted 4 key distinct but related ways systemic racism influences child and youth health in Australia: education quality and access, health care quality and access,⁶⁷ discriminatory incarceration,⁶⁷ and discriminatory child protection and out of home care systems. Each of these systems and settings have actionable leverage points to reduce exposure to systemic racism and promote health equity for children and young people.

Here we focus on strategies for education and health care settings as particular focus areas, though many recommendations are broadly applicable across settings.

Training health and education professionals in anti-racism

While cultural competence and implicit bias training are becoming ubiquitous, evidence suggests they have limited, if any effectiveness without explicit focus on race, racism and power and without accompanying systemic and institutional level action. It is critical that health and education professionals receive specific training in race and racism and build racial literacy in order to recognise racism and racial discrimination present via interpersonal encounters within health care settings and in classrooms, as well as to engender commitment to advocating for structural change and anti-racism action within communities and institutions.^{29,136} Training that ties the patient-doctor relationship – or the teacher-student relationship to population-level racial inequalities, going well beyond brief cultural competency training sessions is urgently needed a focus on the history of race and racialisation and of race as a political project. This is essential to address misconceptions of race as biological or genetic vulnerability or that many inequities experienced by Aboriginal and Torres Strait Islander children, and by some ethnic minority children, are due to socioeconomic factors such as education, income and employment. These discourses persist within health and medicine as well as in education systems and must be countered to address social and structural forces driving health and health inequities. Any workforce development initiatives must go beyond capacity building and address the racism and structural discrimination faced by Aboriginal and Torres Strait Islander and ethnic minoritised staff, and prioritise their safety and their ability to do their work, including addressing issues of race and racism, without obstruction.

Improved reporting and monitoring of racism and racialised inequalities

Regular reviews and data collection on the nature, prevalence, impacts of racism in key settings relevant to children and young people, with child and youth perspectives as central, are needed both to identify areas for action as well as to create accountability for action. This must span self-report data on experiences and impacts, analysis of administrative and other routine data collection, and monitoring of reporting and complaints mechanisms. Measurement and reporting of individual and systemic level racism and discrimination and their impacts on child and youth health must also be prioritised, including analysis of their contributions to child and youth inequities in health, as well as other outcomes. Regular anti-racism audits of organisations, including healthcare, education, local government, sport and recreation, and the media and online settings – with meaningful consequences for inaction are also required and identified as key mechanisms for change.

A critical element of such reporting and monitoring must be culturally safe and sensitive collection and reporting of data on Indigeneity and on ethnicity as a basic requirement.

Legal and policy reform

Law and policy reform are ultimately required to address systemic and institutional racism. This includes major reforms such as endorsement of the Uluru statement and its recommendations and foregrounding of Aboriginal and Torres Strait Islander sovereignty in policy formation and implementation. Commitment to the recommendations of the coronial inquiries into the deaths of Aboriginal and Torres Strait Islander peoples who have died of preventable or avoidable conditions in the health system, and the establishment of an Aboriginal and Torres Strait Islander taskforce to oversee implementation is also needed.⁶⁷ Similar commitments are needed across other sectors, including education, child protection, policing and youth justice. Human rights and equal opportunity legislation, institutional ombudsmen and human rights commissioners at state and national levels, and media regulation and guidelines are also required. At a local level, schools, health care organisations, local government agencies and organisations, need to develop specific anti-racism policies with embedded accountability metrics. Critically, these must be led by and with, local Aboriginal and Torres Strait Islander and community cultural groups, including as appropriate, children and young people.

Funding and commitment to research on the nature and function of race in leading to conditions for racialised health inequalities throughout life, and across generations, including the embodied consequences of racism, is a critical priority.⁶⁷ Given the critical importance of childhood and adolescence to lifelong health, and to health across generations, as well as the limited research on race, racism and embodied consequences early in life, such research must prioritise children and young people.^{43,67,136}

Publication and reporting guidelines that require research, data and analysis relating to racialised health, education and social disparities to foreground systemic and institutional racism, rather than socioeconomic disadvantage and other social and cultural factors, are another key mechanism to advance structural and institutional change.^{43,67,136} This can be enacted across academic journals and publications, in government and institutional reporting, and at a local level within healthcare, schools and other community organisations and settings.

Inter- and Intra- personal level anti-racism

The most recent and comprehensive meta-analysis of interventions to reduce prejudice and improve intergroup attitudes across intra and inter-personal levels among children and adolescents was conducted in 2014, yet findings remain highly relevant.¹³⁰ Overall, interventions were found to be generally effective with a small to medium effect size. However, as the authors identify, most studies use proximal outcome measures, and the majority of studies only examine the immediate effect of programs rather than the long-term effects or the stability of outcomes. This is a considerable issue when it comes to justifying such programs as preventative approaches because long-lasting effects, such as improved intergroup attitudes and reduced prejudice over time are a key goal.¹³⁰

Broadly, the authors suggest that prejudice prevention and promotion of intergroup attitudes are possible via psychological and educational training programs in children and adolescents.¹³⁰ But they also caution that as effect sizes are only moderate, such programs are only one way of dealing with prejudice and negative intergroup relations. This underscores the importance of multi-level, multi-strategy programs and of targeting structural, systemic and institutional change not only focusing on individual-level attitudes and beliefs.

Importantly, interventions to improve ethnic prejudice and inter-ethnic attitudes were identified in the meta-analysis as less effective than those addressing prejudice and attitudes towards people with disability or people who are elderly. The authors suggest this is likely due to higher levels of perceived threat from ethnic minorities as well as stronger anti-prejudice norms towards people with disability and those who are elderly than for ethnic minorities in many western nations.¹³⁰ While much more work is needed, and with research to date predominantly coming from outside of Australia, key learnings of the meta-analysis are highly relevant to the design of anti-racism programs among Australian children and youth. These are summarised and contextualised below.

Structured contact experiences and training in empathy and perspective training most promising– but programs with multi- component and multi-level while including structured contact experiences and training in empathy and perspective taking, are most likely to be effective

Direct contact and training in empathy and perspective taking are identified as the most promising content components, with direct contact leading to better results than vicarious, extended or indirect contact. However, indirect contact is still effective and often more appropriate than direct contact. Direct contact may benefit majority students, but only further marginalise and other those from racialised and minoritised groups and lead to distress and further exclusion. Further, contact alone is considered insufficient for positive effects, whether programs facilitate personal relationships and friendships between groups also seems a critical success factor.¹³⁰ Training in empathy and perspective taking also has a high potential for promoting intergroup attitudes via socio-cognitive abilities, especially for primary school aged children. Moral or values education is seen as also promising, and recent studies suggest it has a central role in prejudice and intergroup attitude development, however, more high-quality evaluations are needed. Promoting dual identity, that is a superordinate social category while also retaining a subgroup identity, has been found to have positive effects, while other forms of social categorisation training were less effective among preschool and primary school children and simple strategies such as “these categories are not important” or “we all belong to one social group of human beings” are not effective and in some cases, counterproductive. Designing and testing programs that span multiple program components and multiple theoretical models, taking into account the most effective elements such as structured contact experiences and training in empathy and perspective taking is a high priority.¹³⁰

Programs require trained leaders actively involved – printed materials and unstructured group discussions produce negative effects

Finally, the meta-analysis identifies two important elements of program delivery linked with success. First, interventions led by a trainer or leader actively involved in the program administration were much more effective than those without, regardless of the person in that role (e.g., teacher, program author or trained student). This is consistent with wider contact literature in which supervision (or taking an active role) by a person with authority is considered one of the beneficial conditions during intergroup contact (Tropp & Prenovost, 2008).¹³⁰ Second, and possibly related, the use of printed materials and group discussions were found to produce negative effects. Printed materials (and increasingly web-based materials) are often used to children teach themselves about prejudice and intergroup attitudes, as are informal group discussions. This important finding reinforces that programs with minimal support from the program administrator or convenor are less likely to deliver significant change.¹³⁰

Program leaders need training in race and racism and in developmental theories and evidence regarding prejudice and intergroup attitude development

It is essential that printed or other materials and group discussions are based on, and guided by, facilitators or teachers who are trained in current developmental theories and evidence regarding prejudice and intergroup attitude development. Critically, teachers and program leaders must also be equipped to understand, and to communicate in age-appropriate ways, how race and racism operate and relate to power in society and institutions. This is a major gap in current programs and activities that needs to be addressed. As noted above, and reinforced again here by these meta-analysis findings, the potential for negative effects and to do harm is high.¹³¹

Anti-racism needs to be compulsory content across all areas and levels of education, repeated and deepened according to age and setting and in addition to cultural competence.⁹

As Bargaille and Lentin recently wrote ‘Just as young Black and Indigenous children know about police racism, white children too can understand how power works in discriminatory and exploitative ways, not only in the shadowy past, but in the here and now. Empowering them to come to their own understandings of how race works by showing them real-life examples from the world today is one way to build racial literacy and create, not only empathy, but warriors for the battle ahead.’⁹ This further reinforces the need for not only multi-modal, developmentally appropriate and evidence-based programs at an intra and interpersonal level, but for multi-level programs that directly address and target systemic and institutional level racism and build racial literacy and anti-racism capacity of students and teachers, as well as institutions and systems. These programs can be delivered online and in person and designed to build anti-racism capacity across settings, e.g. in schools, sport, online.

A recent example of such a program with promising evidence of effectiveness is the ‘Speak out Against Racism’ (SOAR) program.

The SOAR program is a whole of school, multi-level, multi-strategy program that aimed to promote effective bystander responses to racism and racial discrimination in primary schools. Specifically, it aimed to increase knowledge and practical skills for proactive bystander responses to racism and racial discrimination and to improve peer social norms and the school climate regarding racism and racial discrimination. SOAR drew on a multifaceted theoretical background, spanning theory and evidence on anti-racism, anti-bullying, prejudice reduction, child socio-cognitive development and social conflict in schools. This included evidence that the most effective programs are those that are: multi-level, considering stigmatised and non-stigmatised groups across intrapersonal, interpersonal and systemic levels and include all students, those who experience racism as well as those who do not;^{128,131,137} whole of school approaches that include school policies and guidelines, curriculum and pedagogy, teacher training and development, student support and development, parent and community involvement and monitoring and reporting;¹³⁸ focused on age-related cognitive skills and processing such as perspective taking and empathy, multiple classification, dual identity, moral reasoning (thinking and feeling about fairness) not only on intergroup contact;^{130,139} increase school prosocial norms to reduce conflict;¹⁴⁰ and sustained and integrated over extended periods of time.¹³⁸

SOAR spans 6 mutually reinforcing elements: teacher training and development; curriculum and classroom materials; student support and development; parent and community involvement; school policies and guidelines; and monitoring and reporting of racial discrimination.

Teacher training and development: two days of face to face training was provided for classroom teachers delivering the SOAR curriculum and classroom materials as well as any other interested school staff. These training workshops were presented by research staff together with staff from a service provider working with schools to support students of refugee backgrounds. NSW Department of Education staff attended the NSW training and development workshops. After the training workshops coaching sessions were delivered via phone or online throughout the program to enable staff to debrief with the research team and troubleshoot any issues.

Curriculum and classroom materials: the SOAR classroom materials constituted an 8-week unit of work that included suggested activities and questions. The framework for this unit of work and classroom materials were developed by the research team, then workshoped and refined prior to implementation with classroom teachers and school support staff who had experience working with children from culturally, racially and religiously diverse communities, and reviewed by education department staff. These activities were facilitated in-class by classroom teachers, and culminated in the development of a class charter on proactive anti-racist bystander action.

Student support and development: the pedagogical approach of the SOAR program had a strong focus on students as experts and engaged learners throughout. This was foundational to the classroom materials and culminated in ‘Team SOAR’ student-led sessions for the second half of the program. ‘Team SOAR’ was a team of student influencers selected by teachers and classmates at the end of the 8-week unit of work to continue to promote the principles of SOAR. They held student-led meetings to develop materials and activities for their peers and the wider school community.

Parent and community involvement: Team SOAR students developed activities to engage with parents and the wider community, and to communicate SOAR principles more broadly.

School policies and guidelines: An audit tool was provided to support school leadership to review policies and guidelines regarding racism and racial discrimination and to develop a plan for future action in this area. Monitoring and reporting of racial discrimination: Schools were provided with the opportunity for school-level reports on survey data and the audit tool encouraged schools to review their monitoring and reporting systems, policies and guidelines.

A feasibility and acceptability study using a mixed-methods, quasi-experimental evaluated the program across primary schools in NSW and Victorian Students in Years 5 and 6 (10-12 years) across 6 schools completed surveys pre- and post-intervention (N=645; 52% female, 6% Aboriginal and/or Torres Strait Islander, 31% Middle Eastern, African, Latinx, Pacific Islander, or Asian, 52% Anglo/European). Quantitative data showed student prosocial skills and teacher interracial climate improved in intervention schools compared to comparison schools. Qualitative data highlighted teacher attitudinal and behaviour change regarding racism, and student reduced interpersonal racial discrimination, improved peer prosocial norms, commitment to anti-racism, knowledge of proactive bystander responses and confidence and self-efficacy to intervene to address racism.

Summary, data gaps and recommendations

Racism need to be named and addressed explicitly at a systemic, institutional level – too often interventions focus on addressing disadvantage and not on the racism that creates, maintains and justifies that state of disadvantage. Anti-racism efforts must foreground Aboriginal and Torres Strait Islander sovereignty and leadership. Community cultural groups also need to be actively involved as architects and leaders in efforts that impact their communities. Ensuring children and young people are actively involved in co-designing anti-racism efforts is also critical. Anti-racism initiatives also need to be life-course appropriate, that is founded on developmental theories and current evidence regarding the development of prejudice and intergroup attitudes throughout childhood and adolescence. Too often this is not clear or included within anti-racism programs, which increases potential for doing harm including reinforcing stereotypes among those from majority backgrounds and causing distress to those already bearing the burden of racism. It is imperative that prior to large scale implementation programs undergo high quality effectiveness evaluations to ensure they do no harm and do not perpetuate the very issues they are intending to address. This is a major issue for the field, where often good intentions prevail over evidence-based approaches.

At a structural and institutional level, including health and education settings, key areas for action include building racial literacy regarding race, racism and health and founded in developmental theories and evidence. Ensuring that such work also addresses racism experienced by Aboriginal and Torres Strait Islander staff, and staff from ethnic minority backgrounds, within these settings is key. Improved reporting and monitoring of racism and racialised inequalities including large scale data re racism and discrimination as well as ensuring Indigeneity and ethnicity data collection. Legal and policy reform, from action on the Uluru statement recommendations and equal opportunity and human rights mechanisms is also needed. Other priorities include funding and commitment to research on the nature and function of race and racism for racialised health inequalities across key settings, including education, healthcare, sport and online and the embodied consequences of racism among children and young people. Ensuring existing data is analysed comprehensively, and timely collection of new data, are both key priorities. Publication and reporting guidelines regarding reporting of racialised health inequalities are also needed.

At inter- and intra-personal levels, prejudice prevention and promotion of positive intergroup attitudes are possible via psychological and educational training programs in children and adolescents. While the most effective approaches are a combination of intergroup contact and training in empathy and perspective taking, there is an ongoing need for multi-mode and multi-level programs. These need to address both in person and online, cyber-racism as settings for experiencing racism and for anti-racism action. Consensus is that multi-level, multi-strategy programs that target structural, systemic and institutional change not only individual-level attitudes and beliefs, and that are grounded in developmental and theory and evidence, are most effective, though are rarely implemented and tested. Evidence also indicates that effective programs require active involvement of a trained leader or facilitator, with the provision of printed or other materials or group discussions not effective, and likely to do harm. The SOAR program is a program that meets these evidence-based principles. The program was recently piloted in NSW and Victoria with promising findings. Further testing via a large scale implementation trial is now needed.

Summary and conclusions

Racism is a fundamental cause of health and health inequalities. Children and young people are particularly vulnerable to racism's harms. Intergroup attitudes, beliefs and behaviours are also established in childhood, making this a priority time for action.

Racism harms child and youth health through direct exposure to racism and pathways of stressor exposure as well as through the structural and societal legacies of historical and contemporary racism on communities, families and carers and their access to resources. Racism leads to differential access to socioeconomic resources and to a broad range of societal resources and opportunities needed for health. Racism can increase exposure to, and exacerbate negative effects of, other risk factors for health. Behavioural, physiological and psychological responses to racism, as well as individual and collective resilience, are also important mechanisms shaping health outcomes.

Self-reported experiences of racial discrimination are only one indicator of the wider system of racism. The limited Australian data collected in the last 5 years (2016-2020) underscores the high prevalence of racial discrimination experienced by children and young people from Aboriginal and Torres Strait Islander backgrounds, and from some ethnic minoritised groups. However, substantial data gaps remain, and data that does exist is under-analysed.

High quality evidence of effective anti-racism strategies among children and young people is relatively sparse, although promising approaches and key principles for action are identified. Racism must be named and addressed explicitly at a systemic, institutional level – too often interventions focus on addressing disadvantage and not on the racism that creates, maintains and justifies that disadvantage. Anti-racism efforts must foreground Aboriginal and Torres Strait Islander sovereignty and leadership. Community cultural groups need to be actively involved as architects and leaders in efforts that impact their communities. Ensuring children and young people are actively involved in co-designing anti-racism efforts is also critical. Anti-racism initiatives need to be life-course appropriate. That is, founded on developmental theories and current evidence regarding the development of prejudice and intergroup attitudes throughout childhood and adolescence. Not doing so increases potential for doing harm including reinforcing stereotypes and causing distress. Programs must undergo high quality effectiveness evaluations to ensure they do no harm and do not perpetuate the very issues they are intending to address.

At structural and institutional levels, promising anti-racism approaches are initiatives to improve racial literacy among staff, as well as families and communities, regarding race, racism and health together with developmental theories and evidence. Improved reporting and monitoring of racism and racialised inequalities including large scale data re racism and discrimination, organisational audits with accountability for inaction, and ensuring high quality Indigeneity and ethnicity data collection, are also recommended. Legal and policy reform, including action on the Uluru statement recommendations and equal opportunity and human rights mechanisms is an outstanding priority.

At inter- and intra-personal levels, best available evidence suggests that a combination of intergroup contact and training in empathy and perspective taking is most effective. Consensus is that multi-level, multi-strategy programs that target structural, systemic and institutional change not only individual-level attitudes and beliefs, and that are grounded in developmental and theory and evidence, are most effective. Evidence also indicates that effective programs require active involvement of a trained facilitator. Provision of materials or unstructured discussions are not effective, and likely to do harm.

The evidence outlined in this report will enable a more detailed understanding of the response required by VicHealth and its stakeholders to address racism as a fundamental cause of health and health inequalities for children and young people.

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VicHealth is committed to health equity, which means levelling the playing field between people who can easily access good health and people who face barriers, to achieve the highest level of health for *everyone*.



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<https://doi.org/10.37309/2021.MW1027>

VicHealth acknowledges the support of the Victorian Government



VicHealth acknowledges the Traditional Custodians of the land. We pay our respects to all Elders past, present and future.