Racism: the wounds and the barriers

Evidence, lived experience and practice implications

June 2026

QPASTT

Table of contents

About QPASTT

QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma) is a specialist agency that provides culturally responsive services to support the recovery of refugee survivors of torture and war-related trauma.

Acknowledgements

This paper was prepared by Rima Flihan, Team Leader for Advocacy, Research and Training and Counsellor/Advocate, in collaboration with QPASTT practitioners and staff.

For enquiries, contact RimaFlihan@qpastt.org.au.

We acknowledge the consultation participants, including clients, community members, practitioners and staff who generously shared their stories, experiences, and insights.

Executive summary

This document brings together consultation findings, practice insights and relevant literature to explore how racism shapes mental health and trauma recovery for people from refugee and asylum-seeking backgrounds.

The central argument of this paper is that racism interrupts recovery because it undermines the conditions recovery depends on: safety, dignity, trust, belonging, connection and access to support.

It finds that racism is not only experienced as individual or interpersonal incidents, but as a structural and ongoing source of harm. These experiences occur across systems, including health services, education, employment, housing and public institutions, and are often repeated over time.

For people from refugee backgrounds, racism intersects with trauma histories and can affect emotional safety, confidence, identity, family wellbeing and sense of belonging. Through this, it becomes a compounding and cumulative factor in mental health and recovery, acting not only as a stressor but as a form of ongoing trauma.

Key insights include:

Racism across systems and settings

Experiences of racism across health, education, housing and other systems were identified. In health care, racism was shown to affect not only access to services but the quality of care, emotional safety and trust in systems. In education and other settings, racism influenced expectations, participation and long-term opportunities.

Intersection with trauma histories and lived experience

Experiences of racism interact with prior trauma and shape how individuals experience, respond to and recover from distress. These impacts are shaped by intersecting identities, including gender, sexuality, language and migration status, resulting in layered and compounding disadvantage.

Silence, internalisation and power

Racism is often unnamed or internalised due to fear, power imbalances or expectations of gratitude. This can deepen shame and isolation while obscuring the systemic nature of these experiences.

Barriers to help-seeking and engagement

Experiences of racism within systems and services reduce trust and willingness to engage. Services may be technically available, but if interactions are experienced as unsafe or dehumanising, they become effectively inaccessible. In this way, racism operates not only as exclusion, but as a producer of risk, shaping health behaviours and inhibiting access to care.

Racism as a cumulative and ongoing form of trauma

Repeated exposure to racism, discrimination and exclusion contributes to long-term emotional and psychological harm, including trauma responses such as fear, hypervigilance, avoidance and mistrust. These experiences erode safety and belonging and can re-trigger earlier trauma. Services should recognise that harm may arise not only from overt racist incidents, but also from repeated microaggressions, dismissive interactions, assumptions about capability, poor interpreter access and everyday experiences of being treated as less credible or less entitled to care.

Impacts on practitioners

Racism was also found to affect practitioners, contributing to emotional distress, moral injury and reduced capacity to support clients where systems are unsafe or unresponsive. Racism not only affects individual practitioners but inhibits the effective functioning and delivery of services.

These findings highlight that approaches to mental health focused primarily on individual clinical needs are insufficient where they do not account for the structural and relational conditions shaping people's experiences.

Key implications include:

- Mental health must be addressed at the individual and community level as well at a systemic level
- Trauma-informed practice must also be anti-racist and responsive to present-day experiences
- Services must prioritise culturally safe, relational and inclusive care
- Systems must address power, accountability and inequitable access to support

Introduction

This paper argues that addressing racism is central to understanding the mental health and trauma experiences of refugees and people seeking asylum. It contends that mental health for people from refugee backgrounds cannot be fully understood without considering the broader societal conditions that shape safety, belonging and recovery. In practice, this means recovery is shaped not only by what people have survived before arriving in Australia, but also by whether they are treated with dignity, safety and fairness throughout their settlement experiences.

Racism occurs in both interpersonal and systemic forms. As noted by the Australian Human Rights Commission, it can appear through actions, attitudes, systems and policies that treat people unfairly. This includes interpersonal experiences such as harassment, abuse, humiliation, violence or intimidation, as well as systemic forms of racism where laws, institutional practices and structures create and maintain racial inequality. These systemic conditions often enable and reinforce interpersonal racism.

QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma) is a community-based specialist rehabilitation service supporting survivors of torture and refugee trauma through clinical services, community capacity building, training, advocacy and systemic reform.

Between January 2025 and July 2026, 159 QPASTT clients who were engaged in individual counselling identified racism within psychosocial context data in our clinical recording system, NERO. This reflects 28% of our total individual counselling clients. This is likely to underrepresent the full extent of the issue, as racism may not always be named, disclosed or recorded. The adoption of a National Anti-Racism Framework in Australia provides a timely opportunity for QPASTT to strengthen its role in shaping safer systems for survivors of torture and trauma, particularly in a broader context of increasing hate speech, divisive public discourse and global events that can heighten social tension in Australia.

Drawing on consultation with QPASTT practitioners, alongside insights from clients and communities, this paper explores how racism is experienced in everyday contexts and how it shapes access to services, particularly within health and education systems. These practice-based insights provide a foundation for understanding how systemic barriers are experienced and how they affect wellbeing and recovery.

While many refugees and people seeking asylum have experienced significant pre-migration trauma, including war, persecution, displacement and loss, this paper highlights that trauma does not end after resettlement. Post-migration experiences such as racism, discrimination, social exclusion, insecure housing, unemployment, visa uncertainty, language barriers and culturally unsafe services continue to shape distress, recovery and access to care.

In this context, trauma-informed practice must extend beyond past experiences to consider present-day conditions. It is not sufficient to understand what has happened to individuals in the past without also recognising how ongoing interactions with systems and services continue to affect their sense of safety, trust and belonging.

Drawing on the concept of the social construction of difference, this paper understands racism as part of a broader process through which societies assign meaning and value to human differences. These processes shape who is recognised, who belongs, and who has access to resources and opportunity. Within this framework, racism, discrimination and social exclusion can be understood as interconnected expressions of "othering", operating across both interpersonal and systemic contexts.

This paper therefore situates mental health and trauma within these broader social and structural conditions. It examines racism as a post-migration stressor and a cumulative form of harm, before presenting findings that illustrate how these dynamics are experienced in practice. It then considers the implications for service delivery, workforce capability and systems, and sets out recommendations to support more culturally safe, equitable and effective responses.

Purpose and use of this document

This document has been developed as a foundational knowledge resource on racism, trauma and mental health in refugee and asylum-seeking communities.

It is intended to help QPASTT and the broader sector move from recognising racism as a social issue to understanding it as a direct practice, policy and mental health concern.

It brings together consultation findings, practice insights and relevant literature to support a shared understanding of the issue across different contexts and audiences.

Purpose

The purpose of this document is to:

- provide a consolidated evidence base on racism as a determinant of mental health and recovery
- support reflection on practice and service design
- inform sector development and workforce capability
- contribute to policy dialogue and advocacy efforts

This document is not intended as a single-position advocacy paper or submission. It is designed as a source document that can inform and underpin multiple pieces of work.

Intended audiences

This resource has been developed for use across multiple audiences, including:

Internal audiences

- To support reflection on organisational practice, service delivery, and workforce capability

Sector partners and practitioners

- To inform culturally safe, trauma-informed and anti-racist approaches

Policy and decision-makers

- To strengthen understanding of systemic barriers and inform policy and systems reform

Advocacy contexts

- As a foundation for submissions, discussion papers and engagement with government and stakeholders

How this document should be used

The document is designed to be modular and adaptable.

Sections can be:

- read as a whole to build a comprehensive understanding of the issue
- used individually to inform specific discussions or decisions
- extracted and adapted for external outputs, including:
    - advocacy papers
    - submissions and briefings
    - training and organisational development

Limitations

This document draws on consultation and practice insights and does not represent all experiences or contexts.

This document does not constitute a systematic literature review and should not be used as such.

There may be variations in how racism and discrimination are experienced across different communities, settings and systems.

Methodology

This document reflects QPASTT's commitment to anti-racism and client-centred advocacy and is informed by the Australian Human Rights Commission's *The National Anti-Racism Framework: A roadmap to eliminating racism in Australia (2024).* The National Anti-Racism Framework establishes a 10-year whole-of-society approach to dismantling systemic and structural racism across justice, health, education, workplaces, media and data systems and identifies health, justice, education and housing as priority sectors in which racism drives inequitable outcomes.

This work is guided by a qualitative, practice-based design grounded in a trauma-informed framework and QPASTT's values and practice experience.

Approach

The methodology combines:

- Practice-based insights from across QPASTT's programs and services
- A review of relevant literature

This approach supports an understanding of how racism is experienced in practice and how it shapes access to systems such as health and education.

Data collection

A total of 35 participants contributed to this work, primarily practitioners, alongside some clients and community members engaged through QPASTT's programs and services. The findings should be understood as practice-based and qualitative. They are not intended to quantify all experiences of racism, but to identify patterns, impacts, and practice implications emerging across QPASTT's work.

Twenty-five consultations with practitioners and community members were conducted in 2025. These consultations included community members from Townsville, practitioners from Cairns, Toowoomba, and Brisbane, as well as youth groups and workers.

A further ten consultations took place between March 2026 and May 2026. They included LGBTQIA+ multicultural groups and practitioners from regional areas and Brisbane, including children and youth counsellors, adult counsellors, and team leaders. The consultations were conducted face-to-face and online, and participants were given the opportunity to send a written reflection or add further comments after the interview.

Consultation and data collection took place through:

- One-on-one interviews
- Focus group discussions
- Workshops to support deeper exploration of themes

Flexible formats were used to respond to participants' needs and preferences.

Interviews focused on:

- Examples of racism or discrimination experienced by clients
- How these experiences affected their wellbeing, trauma symptoms, sense of trust, views, and engagement
- Observations that stood out in practitioners' work with clients, including client responses, behaviours, or reflections
- How supporting clients through these experiences affected workers, including their emotional responses, thoughts, and motivation in practice

Ethical considerations

The methodology and data collection prioritised safety, trust, and relational engagement. Participation was voluntary, confidential, and conducted using culturally responsive approaches.

Consultation processes, including recruitment and workshop design, were informed by principles of consent, confidentiality and participant safety.

Scope of consultation

Given the intention to understand experiences of racism across programs and service contexts, consultation was undertaken across multiple service areas, including:

- counselling
- youth programs
- community programs

This enabled the identification of patterns across different settings, rather than isolated experiences.

Data analysis

Data was analysed through an iterative process of theme development. This involved:

- identifying patterns across interviews, discussions and workshops
- testing and refining themes through team-based reflection
- drawing on the National Anti-Racism Framework to inform interpretation

Collective reflection within the QPASTT Advocacy, Research, Evaluation and Training team was used to strengthen analytical rigour and support consistency in interpretation.

Conceptual and evidence-informed framework

Key definitions

These definitions draw on both existing literature and practice-based knowledge reflected in QPASTT consultations.

Racism

Racism refers to actions, attitudes, systems, and policies that treat people unfairly based on race, ethnicity, or perceived difference. It operates at both an interpersonal level - through harassment, abuse, humiliation, violence or intimidation - and at a systemic level, where institutional practices and structures create and reinforce racial inequality (Australian Human Rights Commission, n.d.).

In this document, racism is understood as not only individual prejudice but a structural process that determines access to safety, resources, services, and belonging across social and institutional settings.

Discrimination

Discrimination refers to unfair or unequal treatment based on characteristics such as race, ethnicity, language, religion, gender, disability, or migration status.

Racism, therefore, occurs when a person, organisation, or system uses their power to discriminate against, oppress, or limit the rights of others because of their race (Australian Human Rights Commission, n.d.). This definition is important because it places power at the centre of racism, rather than treating racism only as individual prejudice or interpersonal conflict.

Within this document, discrimination is understood as occurring both directly and indirectly, through exclusion, mistreatment, or policies and practices that disadvantage particular groups across systems such as employment, housing, education and health care.

Social exclusion

Social exclusion refers to the processes through which individuals or groups are marginalised and prevented from fully participating in social, economic, and community life (Cameron, 2020; Ore, 2023).

For people from refugee and asylum-seeking backgrounds, social exclusion may occur through barriers to employment, education, housing, services, and community participation. These experiences are often shaped by racism and discrimination and contribute to reduced belonging, safety, and access to opportunity.

Racial trauma

Racial trauma refers to the emotional, psychological and physiological harm resulting from experiences of racism and discrimination. It may arise from single incidents or from the cumulative impact of repeated exposure to racism over time (American Psychological Association, 2019).

Racial trauma can produce symptoms similar to post-traumatic stress, including hypervigilance, anxiety, avoidance, anger, shame and mistrust (Williams et al., 2021). It is often chronic and cumulative, extending beyond discrete traumatic events and requiring adapted approaches to assessment and care (Williams et al., 2021).

Cultural safety

Cultural safety refers to the creation of environments and practices in which individuals feel respected, safe, and free from discrimination or judgement.

Within this document, cultural safety extends beyond cultural awareness. It requires practitioners and organisations to:

- recognise power imbalances
- respond to lived experience
- ensure equitable access, including interpreter use
- address racism and institutional barriers within systems

Cultural safety is understood as a relational and systemic practice, dependent on whether individuals experience dignity, inclusion and belonging in interactions with services. In this sense, cultural safety is not something a service can simply claim. It must be reflected in the experience of the person receiving care.

Theoretical framing

The social construction of difference

The social construction of difference refers to the ways societies, institutions, and systems create meaning around human differences, including race, ethnicity, gender, sexuality, class, religion, disability, language, and migration status. These differences are not neutral; they are shaped by political, historical, cultural, and economic processes that position some groups as “normal,” powerful, and privileged, while marginalising, stereotyping, or excluding others (Cameron, 2020; Ore, 2023).

Although differences themselves are not harmful, people often attach unequal value to different identities. This creates hierarchies in which some groups are privileged while others are marginalised. For people using services, these hierarchies may be experienced in subtle ways: being treated as less credible, less capable, less deserving of support, or less entitled to ask questions and make decisions (Cameron, 2020; Ore, 2023).

Within this context, racism can be understood as part of a broader process of “othering”, through which individuals and groups are positioned as different, unequal, or outside the dominant norm. This process shapes who is recognised, who belongs, and who has access to resources, safety, and opportunity.

Racism, and related experiences of discrimination and exclusion, operate across both social and institutional contexts. As a structural process, it can determine access to employment, housing, education, health care, and social participation, and may result in stereotyping, unequal treatment, and exclusion across systems. Refugees and people seeking asylum may be particularly positioned as

"other" through these dynamics, based on factors such as race, ethnicity, language, religion, culture, legal status, or perceived foreignness.

In this way, the social construction of difference provides the foundation through which racism, discrimination and social exclusion operate, limiting access and participation.

Racism as a structural process

Racism operates at both interpersonal and systemic levels. It may be expressed through direct experiences such as harassment, abuse, humiliation or violence, but is also embedded within institutional structures, policies, and practices that produce and reinforce inequitable outcomes.

As a structural process, racism shapes access to employment, housing, education, health care, and broader social participation. For people from refugee and asylum-seeking backgrounds, this can result in patterns of exclusion, stereotyping, and unequal treatment across multiple settings.

Understanding racism as structural does not minimise interpersonal harm. Rather, it shows that individual incidents often occur within systems that already distribute safety, credibility, opportunity and care unequally.

Intersectionality

Intersectionality examines how different aspects of identity interact within systems of power and inequality to produce unique experiences of oppression and privilege. A person's experience is shaped not by a single factor, but by the interaction of multiple characteristics including race, gender, age, religion, disability, sexuality, class, language and migration status (UN Women, 2022). These identities are experienced within broader structures such as racism, colonialism, patriarchy, ableism and economic inequality, which influence how advantage and disadvantage are produced and maintained.

For people from refugee and asylum-seeking backgrounds, these intersecting identities can result in layered and compounding forms of disadvantage. Racism may intersect with gendered expectations, economic exclusion, visa insecurity or stigma, shaping how individuals experience services, safety and belonging.

For example, refugee women may experience racism alongside gender-based violence and economic exclusion, while refugee men may encounter racial profiling and employment discrimination. Young people may experience racism in schools through bullying and exclusion, and people with disability may face additional barriers to accessing services.

Intersectionality highlights that experiences of racism are not uniform, but are shaped by a person's social location, identity, lived experience and the broader systems through which inequality is produced and maintained.

For practice, this means services need to ask not only "what community is this person from?" but also "what forms of power, exclusion, safety or risk are shaping this person's life right now?"

Racism as a post-migration stressor

Racism and discrimination are significant post-migration stressors for refugees and people seeking asylum. Research has found that discrimination is associated with poorer health, reduced wellbeing, lower levels of trust, reduced belonging, and diminished hope among people from refugee and asylum-seeking backgrounds resettled in Australia (Ziersch et al., 2020).

Refugee mental health care and assessment must therefore consider both pre-migration and post-migration factors. Pre-migration trauma may include experiences such as war, persecution, torture, forced displacement, detention, loss, and family separation. Post-migration stressors such as racism, social exclusion, insecure housing, unemployment, visa uncertainty, poverty, language barriers and culturally unsafe services, can intensify psychological distress and affect recovery (Kronick, 2018).

Racism may communicate to individuals that they do not belong, are not safe, and not valued within society. These experiences can have a cumulative impact over time, particularly where racism occurs repeatedly across workplaces, schools, public spaces, health services, housing systems, media narratives and government institutions. For people who have already experienced persecution, displacement or exclusion, these messages can be especially harmful because they echo earlier experiences of being unsafe, unwanted or without protection.

Racism as a trauma multiplier

Racism can operate as a form of trauma, particularly when individuals experience repeated discrimination, hate crimes, exclusion, or racial violence. It may re-trigger trauma responses, undermine trust in institutions, reduce engagement with services, and contribute to increased isolation, particularly in regional or resettlement contexts where there may already be barriers to community connection and culturally responsive services.

Racial trauma may arise from both acute incidents, such as verbal abuse or hate-based attacks, and from the accumulation of everyday experiences of racism over time. (American Psychological Association, 2019). For people from refugee backgrounds, a racist incident may not be experienced as a stand-alone event. It may connect with earlier memories of violence, state control, humiliation, exclusion or loss of safety. These experiences can produce symptoms similar to post-traumatic stress, including hypervigilance, anxiety, avoidance, anger, shame, intrusive thoughts, and mistrust (Williams et al., 2021).

Williams et al. (2021) highlight that racism can function as a form of traumatic stress with significant psychological, emotional, behavioural and physiological consequences. Racial trauma may result from direct discrimination, repeated microaggressions, systemic exclusion, and vicarious exposure to racist events. Importantly, these experiences are often cumulative, chronic and ongoing, rather than linked to a single event. This means that traditional post-traumatic stress frameworks, which focus on discrete incidents, may not fully capture the impact of racism on mental health.

Williams et al. (2021) also emphasises the importance of culturally responsive and trauma-informed approaches that:

- recognise and validate experiences of racism
- consider racial identity and social context in assessment
- support coping strategies and community connection
- adapt trauma interventions to reflect lived experience

Understanding racism as a trauma multiplier reinforces that trauma-informed practice must attend to both past trauma and present conditions. A person cannot be supported to feel safe if the systems around them continue to communicate that they do not belong.

Findings

Thematic analysis

This section presents findings from consultation with QPASTT practitioners and community members. These findings and subsequent discussion illustrate how racism operates in everyday contexts and how it shapes mental health, safety, belonging, and access to services.

In some examples, racism was explicit. In others, harm was experienced through discrimination, exclusion, inequitable access, cultural unsafety or systems that failed to respond to language, trauma and settlement realities. These experiences are discussed together because they often operate in connected ways and produce similar impacts on safety, dignity, trust and recovery.

Table 1. Examples of racism identified in consultations with QPASTT practitioners

Type of racism, discrimination and/or exclusion	Example from consultation	Impact
Language-based service exclusion	Housing service providers did not work with or refer a young person because he did not speak English well. The practitioner described this as essentially denying a person access to a range of housing options based on language and background.	Unsafe housing continued; trauma was retriggered; reduced access to support; reduced sense of belonging and ability to engage with systems.
Systemic discrimination in housing	A young person was unable to access supported accommodation due to language and background barriers. The practitioner understood these barriers as connected to the young person's identity as a person of colour and refugee-background young person. He remained in a share house with older people who reminded him of people connected to past torture and trauma experiences.	Sleep problems, headaches, disengagement from TAFE, ongoing sense of unsafety, ongoing trauma activation, and limited opportunity to recover.
Rigid service policies	A young person missed an appointment due to illness and lost his place under a "one strike" policy. The service did not appear to consider communication barriers, cultural background, or trauma-related needs.	Became unwell; further exclusion from opportunity and independence; reinforced mistrust and reduced engagement with services.

Type of racism, discrimination and/or exclusion	Example from consultation	Impact
Direct racial abuse	A refugee-background woman was verbally attacked by neighbours, called racist names, told to "go back to where you came from," and her children were targeted in the same way.	Hypervigilance, panic attacks, flashbacks, withdrawal, fear for children, fear of leaving the home, and increased trauma symptoms.
Racial violence	A woman's house was attacked by neighbours, and her children were exposed to racist hostility from people connected to their school/community.	Heightened fear, reduced safety, repeated police contact, increased worry about children attending school, and feeling unsafe in her own home.
Inconsistent responses from authorities	Some police dismissed the woman's concerns and said there was nothing they could do. In contrast, one senior officer validated her experience, told her she belonged, and acknowledged that what happened was wrong.	Dismissal worsened mistrust and fear of calling police; validation felt containing and healing; positive authority response supported safety and belonging.
Visa/status-based exclusion	A child needing a hearing aid faced repeated barriers because access depended on visa-related systems and linked agencies. Despite advocacy, phone calls, and letters, the child did not receive timely support.	Parent felt dehumanised and without rights; client reportedly expressed feeling "like an animal" or "like a dog"; increased hopelessness and loss of dignity.
Health-system stereotyping	A hospital reportedly framed acute distress as "just trauma" because the client was from a refugee background and already linked with a torture and trauma counselling service.	Discharged without adequate acute mental health follow-up; crisis needs were minimised; practitioner had to step in after the crisis; client's needs were not seen fully.
School/community racism and Islamophobia	Young people, including those wearing hijab, were called derogatory names at school. They became fearful of attending	Fear, social withdrawal, reduced sense of safety, restricted self-expression,

Type of racism, discrimination and/or exclusion	Example from consultation	Impact
	school or using social media, especially during periods of increased public racism.	and increased vulnerability to isolation and distress.
Structural othering and dehumanisation	A practitioner described racism as being upheld by social structures that create "us and them" thinking and give people permission to exclude or mistreat others.	Clients may feel they do not belong, are not equal, or only have rights "on paper"; contributes to hopelessness, mistrust, and damaged self-worth.
Lack of interpreter access / culturally unsafe access pathways	Services relied on drop-ins, phone calls, or voicemail systems without meaningful interpreter access or flexible communication options.	Clients could not access the same level of support as English-speaking clients; increased service failure, frustration, and exclusion from basic needs.
Misrecognition of family violence and racialised assumptions	A practitioner noted that some women may avoid police because they fear being misidentified as the perpetrator, especially if they appear angry or distressed when police arrive.	Reduced help-seeking, fear of authorities, increased risk in domestic violence contexts, and reinforced mistrust of systems.
Service rigidity and the "too complex" label	Some services labelled clients as too complex, too hard, or unlikely to engage, rather than adapting to trauma, language, and settlement needs.	Clients were excluded from support; practitioners had to increase advocacy; trauma recovery was delayed by service barriers.
Unequal access to basic rights and resources	Practitioners and clients reported that racism and discrimination affected clients' access to housing, health care, safety, education, transport independence, and emergency support. For example, clients described experiences of direct racist abuse when using public transport, causing feelings of panic, fear for their safety.	Loss of dignity, reduced independence, reduced belonging, worsening trauma symptoms, and blocked recovery.

Discussion

Racism as an ongoing and lived experience across systems

Participants described experiences of racism and exclusion not as isolated incidents, but as repeated experiences across health, education, housing and social services. These experiences shaped whether people could access basic rights, feel safe in institutions, and trust that systems would respond to them fairly.

A strong theme across consultations was the way racism affects women from refugee backgrounds, particularly where racism intersects with trauma histories, gendered expectations, settlement stress, violence against women and immigration systems. These intersecting factors can compound vulnerability and affect women's mental and physical health, especially during sensitive life transitions (MCWH, 2020).

Immigrant and refugee women experience poorer health, including mental health outcomes, compared to Australian-born women (MCWH, 2020). This community faces multiple barriers in accessing mental health support. Studies show that needs are often overlooked, and there are barriers at policy, organisational, and sector levels. Barriers such as the lack of culturally and gender-responsive policies, insufficiently trained bilingual practitioners, inflexible systems, and unaffordable services limit health service utilisation for migrant and refugee women (MCWH, 2020).

In perinatal and health care settings, consultations with women from refugee backgrounds indicated that racism is not an incidental or peripheral factor. Rather, it operates as a structural, relational and embodied force, shaping access to care, the quality of interactions, emotional safety, and families' sense of competence and belonging.

Participants described experiences in which women from refugee backgrounds felt racially othered, scrutinised or inadequately cared for. These experiences were particularly acute for women with visible differences, strong accents, or culturally specific needs.

> "Some women said they would never go back to hospital because of how they were treated."
>
> "They described doctors being shocked, not knowing what to do, and just staring."
>
> "One woman said she decided she would never have another baby because of what happened to her in hospital."

These accounts demonstrate how racism in health care can operate through misrecognition and limited cultural safety, where people's needs are misunderstood or dismissed based on assumptions about identity, language or background. This has direct impacts on health outcomes, emotional safety and dignity. The impacts can extend beyond the immediate episode of care. Racism in health care can affect future help-seeking, trust in hospitals, reproductive choices, emotional safety, dignity and whether women feel their bodies, families and decisions will be treated with respect.

In health and social service systems more broadly, participants described racism occurring through both institutional practices and everyday interactions that shaped how individuals were received, understood and supported. These included:

- lack of interpreter access
- rigid service policies that did not account for trauma or communication needs
- exclusion from housing or support services due to language or background
- stereotyping in health care, where complex needs were reduced to “just trauma”
- visa-related barriers to essential supports

These examples show that racism and exclusion are not only experienced through direct interpersonal harm. They can also occur through service systems that are inflexible, inaccessible or unable to recognise the realities of trauma, language barriers and settlement. In these contexts, services may be technically available, but not genuinely accessible.

In education contexts, practitioners described racism affecting students’ engagement and participation. In one example, students observed peers participating in a racist protest against refugees and immigrants at their school, after which 15 students left, describing feelings of disappointment and feeling unsafe, affecting their sense of belonging. The impact of this incident was not limited to the day of the protest. For students from refugee backgrounds, seeing anti-refugee racism expressed by peers within a school environment challenged the idea that school was a safe or welcoming place.

Other examples included students and parents describing school staff misunderstanding and looking down on them, including assumptions that students from refugee backgrounds could not pursue higher academic study and should instead focus on vocational pathways. Similar patterns were noted across multiple consultations with communities from refugee backgrounds.

Across systems, these experiences resulted in:

- continued unsafe living conditions
- reduced access to care
- increased distress and trauma symptoms
- reduced sense of dignity, belonging and entitlement to support

Taken together, these findings show that racism and exclusion operate cumulatively across systems, shaping both immediate outcomes and longer-term access to opportunity. They also reinforce that recovery is not determined by therapeutic care alone, but by the broader systems people must navigate. Access to safe housing, culturally responsive health care, interpreters, flexible services and fair treatment within institutions all influence whether individuals are able to stabilise, engage with support, and recover.

Intersectional experiences of racism and exclusion

Findings highlight the importance of intersectionality in shaping how racism is experienced.

Participants highlighted how racism intersects with gender expression, sexual orientation, language barriers, refugee background, health status and migration experience. For some people, this meant navigating racism in mainstream settings while also managing stigma, exclusion or lack of safety

within family or community contexts. Participants shared accounts of everyday discrimination across workplaces, public transport, and social spaces. These experiences included being assumed not to understand English, being avoided in public spaces, receiving unequal workloads, and encountering verbal harassment or exclusion. Although some of these incidents were described as “minor”, they had significant emotional impacts, including anger, sadness, frustration and feeling unintelligent or unwanted.

Workplace racism was a significant theme. Participants described being given heavier workloads due to racial assumptions, experiencing bullying from colleagues, and feeling targeted as the only racialised worker in their environment. In some cases, this led to individuals leaving employment or feeling reluctant to attend work. Others described discrimination during job-seeking processes, where they felt judged based on appearance or identity rather than ability. These experiences demonstrate how racism operates both structurally and interpersonally, contributing to economic and psychological stress.

Some participants described feeling unsafe not only in broader society but also within family, cultural or community contexts where sexuality or gender identity was stigmatised. This could leave people with very few places where they felt fully seen, safe or accepted. Others reported needing to adjust how they dress or present themselves depending on the context, reflecting the need to continually navigate risk across different environments. These overlapping identities intensified experiences of vulnerability, exclusion and trauma.

The emotional and psychological impacts described by participants align with the racial trauma framework discussed earlier in this paper. Many reported ongoing effects such as hypervigilance, avoidance of public spaces, reduced confidence, and feeling unsafe outside the home. Some described avoiding sitting near others on public transport or avoiding crowded spaces altogether following experiences of harassment, while others reported constantly monitoring their behaviour, appearance and surroundings in order to anticipate and avoid discrimination.

These responses reflect trauma-related patterns, where repeated exposure to racism produces long-term emotional and psychological harm beyond individual incidents. This is particularly relevant for LGBTQIA+ communities, whose experiences of racism including discrimination, exclusion, fear and identity concealment, can become forms of chronic stress and trauma-related harm (Frost & Meyer, 2023).

Participants’ experiences align with the minority stress theory (Frost & Meyer, 2023), which explains how chronic exposure to discrimination leads to additional psychological burden for marginalised groups. External stressors, such as workplace inequality and public harassment, were combined with internal stressors including anticipation of discrimination, self-monitoring, and emotional suppression. Some participants described “burying” their experiences or distracting themselves to avoid confronting anger, while others reported overthinking incidents or withdrawing socially. These patterns demonstrate how racism produces stress that accumulates over time and shapes everyday behaviour.

Participants described a range of coping strategies focused on self-protection, including withdrawing from harmful environments, avoiding certain spaces or people, and creating personal “safe spaces.” While these strategies supported immediate safety, they also reflected constrained access to

inclusive and supportive systems. In many cases, participants did not feel safe disclosing their experiences or identities within communities or services, further reinforcing isolation.

Despite these challenges, participants demonstrated resilience by continuing to engage in work, public life and social environments. However, this resilience often came at an emotional cost, requiring ongoing adaptation to unsafe or exclusionary conditions. The findings highlight how racism experienced by LGBTQIA+ people from refugee and multicultural backgrounds is not only an individual experience, but a structural and ongoing source of stress or trauma.

In summary, racism, as experienced through LGBTQIA+ community consultation, can be understood as intersectional, minority stress-related trauma. The detailed accounts illustrate how repeated discrimination affects emotional wellbeing, restricts feelings of safety and belonging, and shapes everyday behaviours. These findings underscore the need for culturally safe, inclusive, and trauma-informed support systems that recognise the layered realities of people's lived experiences, rather than treating identity, trauma, racism and belonging as separate issues.

Racism, silence and internalisation

A recurring theme across consultations was that racism often goes unnamed, internalised or normalised. Silence should not be mistaken for absence of harm. For many clients, not naming racism may be a way of staying safe, avoiding conflict, preserving access to services, or managing fear of authority.

Participants described how individuals may not identify experiences as racism, particularly where there are strong power imbalances or expectations of gratitude for receiving services. This was especially evident among women and mothers who already felt overwhelmed. Instead of naming discriminatory treatment as racism, women frequently blamed themselves for not understanding the system, or for doing something "wrong."

> "They turn it inwards. They think they failed."
>
> "There's so much shame. They don't realise the system is the problem."

Internalisation can make racism harder to identify and respond to. When people blame themselves for poor treatment, the responsibility shifts away from systems and into individuals who already have less power.

Internalisation was compounded by language barriers, unfamiliarity with rights, and cultural norms around respecting authority. For some, experiences of danger when interacting with authorities in their country of origin made it difficult to question or challenge discriminatory treatment in Australia. Services may also misread silence as satisfaction, resilience or lack of concern. This creates a risk that racism remains invisible in feedback systems, complaints processes and clinical assessment.

This silence does not reduce the impact of racism. Instead, it deepens harm by increasing shame, reinforcing isolation, and obscuring the systemic nature of these experiences. It also reflects how power shapes not only whether racism occurs, but whether people feel safe enough to name it and whether systems are prepared to respond.

Racism as a barrier to help-seeking

Racism has a direct impact on whether and how individuals access support. In this context, reluctance to seek support should not be interpreted as passivity or disengagement. It may reflect a learned and reasonable caution about systems that have previously been unsafe, dismissive or difficult to navigate.

Consultation findings demonstrate that when refugees experience discrimination across systems such as health, housing, education, employment, policing, welfare or immigration, they become less willing to disclose distress or seek support. This is particularly significant within mental health care, where trust, safety, confidentiality, interpreter access and cultural humility are essential to effective engagement.

If services are perceived as judgmental, culturally unsafe, or connected to institutions that have previously caused harm, individuals may avoid seeking care until distress becomes more severe. This may be further compounded by stigma surrounding mental health, limited culturally appropriate services, fear of authority, uncertainty about confidentiality, financial stress, transport barriers, and limited knowledge of available supports.

In regional or rural resettlement areas, these barriers may be intensified due to fewer specialist refugee services, reduced interpreter availability, smaller ethnic communities and increased visibility as racialised minorities. Social isolation and challenges with social integration have also been linked to poorer physical and mental health outcomes among humanitarian migrants in Australia (Chen et al., 2019).

Consultations with community groups highlighted that decisions to avoid services, even when medical care was needed, were often shaped by previous experiences of humiliation, dismissal or discrimination. This avoidance was not irrational, but a protective response, grounded in lived experience.

> "Some women don't want to go back to hospital because of the experience they had."
>
> "Safety isn't just about access. It's about how you're treated when you get there."

This distinction is critical. A service may be available on paper, but if a person expects to be judged, misunderstood, denied an interpreter or treated as less credible, that service may not be experienced as genuinely accessible.

These findings demonstrate that access must be understood as relational, cultural and racialised, not only logistical. Services may be technically available, but where interactions are experienced as racist or dehumanising, they become effectively inaccessible.

Participants noted that this was particularly concerning in perinatal contexts, where access to safe and supportive care is critical:

> "Avoiding care increases the risk, but from their perspective, going back feels worse."

In this way, racism operates not only as a form of exclusion, but also as a producer of risk, shaping health behaviours and increasing vulnerability. These patterns reinforce that improving access requires more than service availability - it requires addressing how racism shapes trust, safety and engagement within systems.

Racism, trauma and mental health

Findings from consultations reinforce that racism is closely connected to trauma responses and significantly shapes mental health and recovery for people from refugee and asylum-seeking backgrounds.

For individuals who have experienced war, persecution, torture, displacement, family separation or detention, racism may function as a trauma trigger. Experiences such as verbal abuse, exclusion, racial profiling, hostile public attitudes or discriminatory treatment within services can echo earlier experiences of danger and re-trigger fear, hypervigilance, shame, avoidance, anger, emotional numbing and mistrust.

These responses may worsen symptoms of post-traumatic stress disorder, depression, anxiety, somatic distress and social withdrawal. Racism can also reinforce feelings of powerlessness and unsafety, particularly for people who have previously experienced violence, persecution or state control. In this way, racism does not only cause emotional harm. It can also reactivate earlier trauma and interrupt recovery.

The World Health Organisation identifies racism, discrimination, social exclusion, insecure legal status, poor living conditions and barriers to services as key post-migration determinants affecting refugee and migrant mental health (World Health Organization, 2025). These findings reinforce that trauma-informed practice must also be anti-racist and responsive to present-day conditions, rather than focused only on past events.

Consultations with QPASTT practitioners highlighted that racism affects trauma recovery through both direct interpersonal harm and indirect systemic exclusion.

These experiences contributed to heightened distress, as well as feelings of exclusion, hopelessness, dehumanisation and lack of belonging. Together, they illustrate how racism operates not only as an individual experience, but as a structural condition shaping recovery environments.

The findings also align with existing literature on racial trauma. Research indicates that racism can operate as a form of traumatic stress, resulting from both direct experiences of discrimination and cumulative exposure across time (American Psychological Association, 2019; Williams et al., 2021). These experiences can produce symptoms such as intrusive thoughts, avoidance, anxiety, depression, anger, hypervigilance, physiological arousal and beliefs that the world is unsafe.

Importantly, this body of work highlights that racial trauma is often cumulative, chronic and ongoing, rather than linked to a single discrete event. As a result, traditional trauma frameworks may not fully capture its impact, which has implications for assessment. The literature emphasises the importance of trauma-informed approaches that:

- recognise and validate experiences of racism, including current exposure to racism, exclusion or institutional harm
- consider social and cultural context in assessment
- support culturally adapted interventions
- address systemic as well as individual factors

Taken together, these findings demonstrate that racism affects mental health through both direct harm and indirect exclusion. It can cause distress, reactivate trauma, reduce trust, delay help-seeking and block access to the systems people need for recovery.

Practitioner experience and moral distress

The relevance of practitioner experience is not that it should be centred over client experience, but that it reveals how racism affects the whole service environment including the capacity of practitioners and organisations to provide safe and effective support.

Some practitioners described feeling shame, particularly where harmful policies and systems were associated with white-dominant institutions. They also described heartbreak when witnessing clients' pain and experiences of injustice. The impact on practitioners was described as stemming not only from hearing clients' trauma stories, but from witnessing how systems continued to harm or exclude clients in the present. Racism was described as not only "re-traumatising" but, at times, actively "traumatising" in the present. Practitioners also described feeling limited when services were unsafe, inaccessible, or unwilling to support clients. This affected their sense of professional usefulness, as they struggled to identify safe and appropriate referral pathways.

One practitioner reflected that their practice had changed over time, becoming more realistic and less likely to offer false hope. For example, rather than simply advising a client to contact police, they would now explore whether the client felt safe doing so, what concerns they might have, and whether appropriate supports, such as interpreter services, would be available.

Practitioners also strongly emphasised the importance of integrating counselling and advocacy. They described advocacy not only as system navigation, but as part of therapeutic care, including co-regulation, psychoeducation, capacity-building, dignity repair, and providing corrective relational experiences where systems had failed. This finding is important because it challenges narrow views of counselling as separate from systems advocacy. As QPASTT's practice model (Kaplan, 2020) recognises, where racism blocks access to safety, housing, health care or dignity, advocacy plays a critical role in trauma recovery work.

Across these themes, the findings consistently demonstrate that racism operates as a structural, relational and cumulative force, shaping both lived experience and access to systems in ways that directly impact mental health and recovery.

Table 2. Impacts of racism on QPASTT practitioners

Impact	Description	Meaning for practice
Anger and distress	Feeling angry, upset, and furious in response to discriminatory practices. These feelings were strongest when clients were denied interpreters, excluded from support, or neglected by institutions.	Racism and discrimination affect practitioners emotionally, especially when they witness clients being harmed or excluded by systems.
Shame	In one consultation, a practitioner from an Anglo-Saxon background described feeling shame, particularly because many harmful policies and systems were connected to white-dominant institutions and structures.	Practitioners may experience shame when they recognise how racism is reproduced through systems they are professionally connected to, even when they personally oppose racism.
Heartbreak and sadness	The practitioner stated that racism "breaks my heart," especially because clients are being hurt and denied basic rights.	Practitioners can be emotionally affected by witnessing the pain and injustice clients experience through racism. For practitioners who are people of colour or who have lived experience of racism, client experiences may also connect with their own experiences of harm.
Emotional labour	The counsellor spent significant time in supervision processing anger and distress. They also used personal time and emotional energy trying to understand stakeholder behaviour and find creative ways to communicate with them.	Practitioners carry additional emotional labour when systems are discriminatory, unresponsive, or difficult to engage.
Supervision time diverted from client work	The counsellor reflected that supervision time used to process their own feelings could have been used more directly for client-specific work.	Racism affects not only clients but also practitioner capacity, supervision focus, and professional resources.
Reduced sense of usefulness	Practitioners described racism and systemic barriers as affecting how useful they felt, because they struggled to find safe services or referral pathways for clients.	Practitioners may feel professionally limited when systems repeatedly fail clients or refuse to provide accessible support.

Impact	Description	Meaning for practice
Role confusion and blurred boundaries	Because systems failed to collaborate, the counsellor took on tasks outside their usual role. They worried this could disrupt the therapeutic relationship because counselling, advocacy, and material support became blurred.	Systemic discrimination can push counsellors into casework or advocacy roles, creating boundary and role tension.
Therapeutic advocacy as necessary practice	In the consultations, the practitioners described counselling and advocacy as "both arms working together," especially when clients had already been rejected or ignored by services.	Advocacy can become part of trauma-informed counselling when racism blocks safety, dignity, housing, health care, or service access.
Moral distress	The counsellor considered reporting the school's behaviour as neglect or discriminatory abuse but worried this could worsen the school relationship and create consequences for the child.	Practitioners may feel trapped between protecting the client and managing risks created by powerful institutions.
Changed worldview / increased realism	Some practitioners said working with racism and discrimination changed their view of the world, making them more realistic and less likely to offer false hope about systems.	Practitioners may adapt their practice by acknowledging the real risks clients face when engaging with systems.
Increased responsibility to create safety	A practitioner from an Anglo-Saxon background reflected that, as a white practitioner, they may look like people or systems that have harmed clients, so they work intentionally to show safety, name racism, and provide a corrective experience.	Practitioner identity, trust-building, and anti-racist practice become central to creating therapeutic safety.
Motivation and fuel for advocacy	The practitioner described shame and heartbreak as giving them "fuel" to act, name racism, and use their professional power to support clients.	Emotional responses can become motivation for ethical action, advocacy, and anti-racist practice.

Implications for practice and systems

The findings show that racism is not an isolated or secondary issue to be addressed after therapeutic goals are met. Rather, it is one of the conditions shaping those needs, including whether people feel safe, whether they seek support, and whether recovery is possible. Addressing the impacts of racism requires changes not only at the level of individual practice, but across service systems and policy settings.

Implications for service delivery

Experiences of racism shape how individuals engage with services, influencing trust, safety and willingness to seek support. These patterns reflect the broader social construction of difference, through which interactions within systems can reinforce "othering" or contribute to a sense of recognition and belonging.

Service responses must therefore move beyond a narrow focus on individual clinical needs to acknowledge the relational and structural conditions shaping clients' experiences. Mental health cannot be understood solely as an individual concern when racism, exclusion and inequitable access continue to affect wellbeing in the present. Rather, it must be situated within the broader systems and environments through which safety, trust and recovery are negotiated.

Consistent with the barriers identified in help-seeking, culturally safe and trauma-informed care must be actively experienced rather than assumed. This requires delivering services from a trauma-informed practice framework that:

- prioritises respectful, non-judgmental interactions
- creates environments where clients feel safe to disclose experiences of racism
- ensures confidentiality, trust and relational continuity
- recognises that past and ongoing experiences with systems shape current engagement

These are not additional features of good practice. For people who have experienced racism and trauma, they are core conditions for engagement.

Where service interactions are experienced as unsafe, dismissive or discriminatory, individuals may disengage from care altogether. This underscores that access is not simply a matter of service availability but is shaped by the conditions under which people are received and supported.

This dynamic reflects the conceptualisation of racism as a structural process, in which institutions and service systems play an active role in shaping inclusion or exclusion. Service encounters can therefore either reproduce existing inequities or contribute to safety, dignity and belonging.

Addressing racism within service contexts, including perinatal care, requires more than cultural competence. It calls for recognition of power, accountability for harm, and a sustained commitment to culturally safe and relational practice that honours the dignity, knowledge and resilience of people from refugee and asylum-seeking backgrounds. Without this, services risk treating distress while leaving the underlying conditions that produce harm unchanged.

Implications for culturally safe and anti-racist practice

Culturally safe practice extends beyond cultural awareness or generalised diversity approaches. As demonstrated throughout the analysis, responses must engage with the structural and relational dynamics that shape how racism is experienced within systems.

To respond effectively, services must adopt explicitly anti-racist and anti-oppressive practices and trauma-informed models that:

- recognise and respond to power imbalances between clients and systems
- validate experiences of racism as real and impactful
- avoid reducing complex experiences to "just trauma"
- incorporate culturally responsive communication, including interpreter access
- centre dignity, knowledge and lived experience

Practitioners play a critical role in supporting clients to understand their experiences of racism, discrimination and exclusion within broader social and structural contexts, rather than internalising blame. Anti-racist practice also reflects the need to engage with racism as a present and ongoing condition shaping mental health and recovery.

Traditional post-traumatic stress frameworks may not fully capture racial trauma, as they often focus on discrete traumatic events rather than the cumulative impact of racist experiences across the lifespan. There is therefore a need for approaches that explicitly recognise racial trauma, including assessment tools and interventions that address ongoing exposure to racism, validate experiences of discrimination, consider ethnic identity and systems of oppression, and support culturally adapted trauma-focused care (Williams et al., 2021).

Implications for workforce capability

There is a need for strengthened workforce capability to respond to racism as a determinant of mental health and recovery. Workforce development should include practical capability in recognising and responding to racial trauma. This includes asking directly and sensitively about racism, racial identity, safety and sociocultural context; validating clients' experiences of discrimination; using psychoeducation; supporting connection to community and identity; and adapting trauma-focused interventions to reflect the lived realities of racism and exclusion.

Mental health professionals require:

- training beyond cultural awareness, including:
    - understanding racism as structural and cumulative
    - recognising racial trauma and its impacts
    - responding appropriately to disclosure of racism
- improved assessment practices, including the ability to:
    - ask directly and sensitively about experiences of racism
    - recognise how racism interacts with trauma histories
    - access to evidence-based and culturally adapted interventions

Racism functions as a trauma multiplier, contributing to symptoms consistent with post-traumatic stress. This reinforces the need for practice approaches that integrate trauma-informed and anti-racist frameworks.

Without this capability, there is a risk that services will continue to misrecognise or minimise the impact of racism, limiting effectiveness of care.

Implications for access and service systems

Racism frequently operates through system-level barriers that affect access to basic services, including health, housing, education and social support.

Addressing these barriers requires system-level responses, including:

- ensuring consistent access to interpreters and culturally appropriate communication
- reviewing service policies that inadvertently exclude or disadvantage clients
- addressing rigid processes that fail to account for trauma, language and settlement realities
- strengthening pathways to safe, accessible and responsive services

Policies that appear neutral can still produce inequitable outcomes when they do not account for language barriers, trauma impacts, transport limitations, visa conditions, digital access or unfamiliarity with service systems.

The findings demonstrate that exclusion from services is not only a practical barrier but contributes to ongoing trauma, reduced trust and diminished belonging.

Implications for trust, safety and help-seeking

Trust is a central factor in engagement with services and is directly shaped by experiences of racism. Trust is not built through statements of inclusion alone, but through repeated experiences of being listened to, believed, communicated with properly, and treated as entitled to care.

Where individuals experience racism, discrimination, stereotyping or dismissal, trust in services is reduced, and help-seeking may be delayed or avoided. These responses are often protective, rather than reflective of disengagement or lack of motivation.

Services must prioritise:

- building and maintaining trust over time
- recognising past harms within systems
- ensuring consistency in respectful and culturally safe care
- creating feedback and accountability mechanisms for clients

Addressing racism within services is essential to improving access and outcomes, consistent with the finding that racism acts as a barrier to help-seeking and a producer of risk.

Implications for intersectional and inclusive practice

Racism is experienced differently depending on intersecting aspects of identity, including gender, sexuality, language, disability, and migration status. Individuals may experience exclusion across multiple environments simultaneously, including within their own communities.

An intersectional approach helps avoid assuming that all people from a community experience racism in the same way, or that cultural identity is the only factor shaping safety and access.

Services must adopt intersectional approaches that:

- recognise diverse and layered experiences of discrimination and exclusion
- respond to the specific needs of different groups
- avoid one-size-fits-all approaches to cultural safety
- ensure inclusion within both mainstream and community-specific contexts

Implications for practitioner wellbeing and system capacity

Racism also affects practitioners, contributing to emotional distress, moral injury, and reduced sense of professional effectiveness.

Practitioners reported:

- anger and distress in response to client experiences
- shame associated with systems of inequality
- reduced ability to support clients due to lack of safe referral pathways
- role tension where advocacy becomes necessary to address systemic gaps

These impacts highlight that racism is not only a client issue but a systemic issue affecting service capacity.

Supporting practitioners requires:

- access to supervision that acknowledges systemic injustice
- recognition of the emotional labour involved in responding to racism
- organisational support for advocacy and systemic change
- integration of counselling and advocacy where necessary

Supporting practitioner wellbeing is therefore also a service quality issue. When practitioners are unsupported in responding to racism, the burden is carried individually rather than addressed organisationally or systemically.

Recommendations

The findings and implications of this paper highlight the need for coordinated action across service delivery, workforce capability, and broader systems. Addressing racism as a determinant of mental health and recovery requires changes not only in individual practice, but in the structures and conditions through which people access support, safety and belonging.

1. Strengthen culturally safe and anti-racist service delivery

All service sectors should embed culturally safe, trauma-informed and anti-racist practice across health, education, employment and social service systems.

This includes:

- ensuring culturally safe care that recognises power, accountability for harm, and the dignity and knowledge of refugee and asylum-seeking families
- funding and monitoring consistent and meaningful interpreter access across all services as a core safety requirement
- strengthening relational approaches to care that support trust, safety and belonging
- addressing institutional racism and culturally unsafe practices within service delivery

Services must actively respond to how racism shapes experiences of safety, trust and help-seeking.

2. Build workforce capability in trauma-informed and anti-racist practice

All service sectors should embed specialised, practice-based training across systems to strengthen capability in responding to racism and trauma.

This includes:

- embedding trauma-informed and anti-racism training across health, education, employment and welfare systems, including frontline, management and leadership roles
- ensuring training goes beyond awareness and builds practical capability in:
    - understanding refugee and asylum-seeking experiences
    - recognising the psychosocial impacts of forced migration
    - responding to racism and discrimination
    - working effectively with interpreters
- integrating training into induction, leadership development and ongoing professional development

Sustainable workforce approaches should include mechanisms to monitor impact and support continuous quality improvement across systems.

3. Strengthen partnerships and centre lived expertise

Services should consider strengthened partnerships with QPASTT (or similar specialist refugee trauma recovery organisations) and centre lived experience in workforce development, service design and policy.

This includes:

- partnering with QPASTT as Queensland's specialist refugee torture and trauma service
- incorporating co-design and co-facilitation with people with lived experience in training and systems development
- recognising the value of lived experience in shaping culturally responsive and effective services
- ensuring lived experience involvement is appropriately supported, remunerated and not tokenistic

QPASTT's approach combines specialist clinical expertise with practice-based knowledge and lived experience perspectives, supporting more relevant and effective responses to trauma and racism.

4. Address systemic barriers and inequitable access

All service sectors should implement system-level reforms to address barriers across health, education, housing and social services.

This includes:

- ensuring equitable access to services regardless of language, race, cultural background, religion, visa status, or English proficiency
- removing barriers linked to interpreter access, service entry processes and rigid policies
- strengthening access to housing, health care, education and social support
- improving coordination between services to reduce exclusion
- reviewing eligibility criteria and service entry processes for unintended exclusionary impacts

5. Embed anti-racist accountability in systems and organisations

All service sectors should move beyond symbolic diversity and inclusion measures by embedding anti-racist accountability across systems.

This includes:

- embedding anti-racist accountability in recruitment, leadership pathways and organisational decision-making
- integrating equity and anti-racism indicators into strategic planning and reporting
- establishing mechanisms to monitor and evaluate the impact of anti-racism initiatives
- establishing safe, accessible and culturally appropriate complaints and feedback pathways

6. Support intersectional and inclusive responses

All service sectors should ensure responses explicitly address intersectional experiences of racism and exclusion.

This includes:

- recognising compounded exclusion experienced by LGBTQIA+ people from refugee, asylum-seeking and multicultural backgrounds
- supporting inclusive and safe environments across both mainstream and community settings
- developing targeted approaches that respond to different social positions and lived experiences
- ensuring services do not assume family, cultural community or mainstream services are automatically safe for all clients

7. Strengthen practitioner support and system capacity

Organisations should support practitioners to respond effectively to racism within systems.

This includes:

- recognising and responding to the emotional and moral impacts of racism on practitioners
- strengthening supervision and reflective practice structures
- recognising advocacy as a legitimate component of trauma-informed practice where systems create or sustain harm
- improving access to safe referral pathways

Conclusion

Racism is not a secondary or peripheral issue in the lives of refugees and people seeking asylum. It directly shapes mental health outcomes, trauma experiences, and pathways to recovery, often long after resettlement and the acquisition of citizenship.

While many individuals arrive with histories of war, persecution, displacement and loss, this paper demonstrates that recovery is profoundly influenced by post-migration conditions. Racism - experienced through everyday interactions and embedded within systems such as health, education, housing and social services - operates as a persistent and cumulative form of harm. These experiences can re-traumatise individuals, undermine safety, and disrupt access to care and support.

Drawing on the frameworks of social construction of difference and intersectionality, this paper has shown that refugee experiences cannot be understood in isolation from broader structures of power and inequality. Racism is not only enacted through individual acts, but is socially produced and institutionally reinforced, shaping who is recognised, who belongs, and who has equitable access to resources and care.

Findings from QPASTT consultations illustrate how these dynamics play out in practice. Experiences of racism were reflected in barriers to interpreters, exclusion from services, stereotyping in health care, discrimination in schools, and unsafe housing conditions. These experiences contribute to increased distress, reduced trust in systems, and reluctance to seek help. Importantly, racism often goes unnamed or internalised, deepening harm while obscuring its systemic nature.

The findings also highlight that the impacts of racism extend beyond clients to practitioners. Counsellors and community workers experience moral distress, emotional impact and reduced professional capacity when systems fail to provide safe and equitable support. This reinforces that racism is not only a client issue, but a system-level issue affecting the functioning of services and the ability to provide effective care.

This evidence points to a clear conclusion: trauma-informed practice must also be anti-racist. Addressing past trauma alone is insufficient where present-day systems continue to reproduce harm. Improving mental health outcomes requires not only service provision but transforming the conditions in which people live.

Creating environments where people experience safety, belonging and dignity is essential - not only for individual recovery, but for building more equitable and just systems. Addressing racism is therefore not an optional consideration, but a fundamental component of effective mental health care, service delivery and social inclusion.

Without addressing racism, mental health systems risk treating symptoms while leaving the conditions that produce and compound harm untouched. For refugee and asylum-seeking communities, recovery requires more than access to services. It requires systems that actively support dignity, safety, justice and belonging.

References

American Psychological Association. (2019, February 13). *Uncovering the trauma of racism*. https://www.apa.org/pubs/highlights/spotlight/issue-128

Archer, D. C., & Women of Colour Australia. (2021). *Women of Colour Australia workplace survey report 2021*. Australian Human Rights Commission. https://itstopswithme.humanrights.gov.au/resourcehub/women-colour-australia-workplace-survey-report-2021

Australian Human Rights Commission. (2024). *The National Anti-Racism Framework: A roadmap to eliminating racism in Australia*. Australian Human Rights Commission.

Australian Human Rights Commission. (n.d.). *What is racism*? https://humanrights.gov.au/know-your-rights/rights-of-individuals/race-discrimination/guides,-tools-and-resources/what-racism

Cameron, R. (2020). *Working with difference and diversity in counselling and psychotherapy*. SAGE Publications.

Chen, W., Wu, S., Ling, L., & Renzaho, A. M. N. (2019). Impacts of social integration and loneliness on mental health of humanitarian migrants in Australia: Evidence from a longitudinal study. *Australian and New Zealand Journal of Public Health, 43*(1), 46–55. https://doi.org/10.1111/1753-6405.12856

Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology*, 51, 101579. https://doi.org/10.1016/j.copsyc.2023.101579

Kaplan, I. (2020). *Rebuilding shattered lives: Integrated trauma recovery for people of refugee background* (2nd ed.). Victorian Foundation for Survivors of Torture Inc. (Foundation House).

Kronick, R. (2018). Mental health of refugees and asylum seekers: Assessment and intervention. *The Canadian Journal of Psychiatry, 63*(5), 290–296. https://doi.org/10.1177/0706743717746665

Multicultural Centre for Women's Health. (2020, December 3). Policy brief: *Immigrant and refugee women's mental health*. https://www.mcwh.com.au/policy-brief-immigrant-and-refugee-womens-mental-health/

Ore, T. E. (2023). Making systems of privilege visible. In *The social construction of difference and inequality: Race, class, gender, and sexuality*. Oxford University Press.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS ONE*, *10*(9), e0138511.

Williams, M. T., Osman, M., Gran-Ruaz, S., & Lopez, J. (2021). Intersection of racism and PTSD: Assessment and treatment of racial stress and trauma. *Current Treatment Options in Psychiatry, 8*, 167–185. https://doi.org/10.1007/s40501-021-00250-2

World Health Organization. (2025, September 1). *Refugee and migrant mental health*. World Health Organization.

Ziersch, A., Due, C., & Walsh, M. (2020). Discrimination: A health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia. *BMC Public Health, 20*, Article 108. https://doi.org/10.1186/s12889-019-8068-3