ANTI-RACISM/ANTI-OPPRESSION FIDELITY ASSESSMENT SCALE

ASSESSMENT GUIDE

Center for Research on Inner City Health

ACROSS BOUNDARIES

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The Assessment Tool was developed at the Centre for Research on Inner City Health in partnership with Across Boundaries: An Ethno-Racial Mental Health Centre. The tool has been developed based on an (i) extensive review of the literature in anti-racist and anti-oppression practices; (ii) interviews with mental health experts and researchers; and (iii) through the use of confirmatory methods examining the degree of consensus on the domains of the fidelity scale among those familiar with AR/AO theory and practices. Lessons learned from community consultations have also been incorporated into this tool.

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INTRODUCTION

Groups that face oppression and racism at the individual, institutional, or systemic level are at an increased risk for poor mental and physical health, associated with decreased access to health care and social services. For example, research shows that immigrants and ethno-racial groups use mental health services less frequently compared to non-immigrants and experience signficant barriers to care (Laroche 2000), and that lesbian, gay, bisexual, and transgender (LGBT) individuals are at a higher risk of suicide (Haas et al., 2011).

Furthermore stigmatized categorizations of gender, sexuality, ethnicity, race, citizenship, language, age, ability and disease status *intersect*, leading to multiplied vulnerabilities, or intersectional stigma and discrimination. For example, the invisibility of service needs and characteristics of senior LGBT individuals (Shankle et al., 2003); low quality maternity care for immigrant women (Higginbottom et al., 2014); decreased accessibility of high quality care for post partum deppression among immigrant and refugee women (O'Mahony & Donnelly, 2013); lower breast and cervical cancer screening rates in women with intellectual and developmental disabilities (Cobigo et al., 2013); insufficient and ineffective primary care for aboriginal peoples (Shah et al., 2003); and disproportionate HIV infection rates among Black women (Carmer et al., 2011).[1]

Research has demonstrated that specific groups continue to experience numerous barriers to acessing appropriate health services; these barriers can be divided into factors at service-user, service-provider, and systemic levels. These barriers are particularly alarming given the high rates of mental illness, chronic and infectous disease and substance abuse issues observed in marginalized groups in Canada and worldwide.

There are likely a range of factors that contribute to the lower rates of access and service use experienced by marginalized groups at the *service-user* level including distinct perspectives about mental health and illness; culturally alternative interventions and treatment; lack of information about services; cultural mistrust; communication problems (REF). The factors that have been identified at the *service-provider* level include a perceived lack of provider knowledge, inquiry, nonjudgemental acceptance of traditional beliefs/practices, quality of interpreter services and a lack of gender-concordant translators and service providers (Ngo-Metzger et al., 2003). Racism and oppression can act *systemically*, entrenching and reinforcing barriers to appropriate and quality care at the service-user and service-provider levels.

We propose using an anti-racism/anti-oppression framework to examine health and social service provision systems in order to reduce barriers to care and improve equitable and accessible care for all.

[1] The literature regarding these disparities is extremely broad; the examples provided are from the Canadian context are intended to be illustrative rather than exhaustive.

ANTI-RACISM AND ANTI-OPPRESSION PRINCIPLES AND PRACTICES

Opression can be defined as a "system of domination that denies individuals dignity, human rights, social resources and power" (Dominelli 2008: 10). This discrimination can include, but is not limited to: ableism, ageism, sexism, heterosexism, cissexism, genderism**,** racism, eurocentrism, xenophobia, anti-semitism, Islamophobia, and classism. Racism is a powerful form of oppression that has real consequenses for racialized and marginalized groups, who face barriers and challenges to their health and well-being. Racism can be defined as policies, practices, processes and/or representations and ways of thinking at the individual, institutional, systemic or cultural level that serve to unfairly exclude or disadvantage racialized persons. It is important to acknowledge and recognize the ways in which racism and oppression are embedded into the health and social service system.

The philosophy of anti-racism and anti-oppression (AR/AO) is built on three core values:

i. that racism and oppression have profound negative effects on health and mental health;
ii. that clients need to heal in ways that are meaningful and relevant to them; and
iii. that and that racism and opression can occur at both the individual and systemic level and that intervention is needed at both levels.

Anti-racism (AR) is concerned with transforming existing unequal social relations and restoring power imbalances by confronting its institutional, individual, and cultural dimensions. An ant-racist framework focuses on the impact of racism on health and mental health, and makes explicit the ideal of "internalized racism" and its possible impacts.

Anti-oppression (AO) recognizes the forms of oppression that happen to people based on their race as well as such characteristics as their gender identity, sexual identity, choice of religion, socioeconomic status, citizenship status, age, and mental or physical ability. Anti-oppression expands from "the narrow, exclusive focus on racial oppression to a broader, more inclusive understanding of the links between various forms and expressions of oppression" (Macey & Moxon 1996: 309). Anti-oppression can be seen as a theory that guides practitioners on how to address the issues of dignity, human rights, access to resources and power. Like anti-racism, anti-oppression recognizes the existence of power imbalances and provides a framework for addressing them through the principles of: empowerment, education, alliance building, language use, alternative healing strategies, advocacy, social justice/activism and the fostering of reflexivity.

In general, AR/AO principles offer a promising approach to serving the diverse needs of people from racialized and marginalized groups and strengthening the service systems designed to support them.

PURPOSE OF THE ASSESSMENT TOOL

As part of the At Home Chez Soi project, researchers at the Centre for Research on Inner City Health have developed an assessment tool to measure fidelity to AR/AO principles within the context of a Housing –First program for racialized homeless individuals with mental health problems. The fidelity assessment tool sets out key strategies for AR/AO practice, and includes criteria for fidelity to AR/AO principles and a corresponding scale and method of assessment. This tool is intended to provide health and social service organizations with an effective and systematic way to measure their current level of AR/AO practice and to identify areas for improvement.

While the AR/AO Assessment Tool has been developed for organizations currently employing anti-racist and anti-oppression principles and practices, it may be of equal use in assisting organizations that are looking to implement such a framework for the first time through laying out key criteria, guiding questions and examples.

USING THE ASSESSMENT TOOL

This tool has been developed for use by any health or social services organization or provider, and may be adapted to suit specific resource constraints. Assessment using the tool may be completed internally or with technical assistance from an external group, and will require organizational commitment to funding and access to management, front line staff, service users, and agency documents.

Organizations are assessed along the following twelve criteria for fidelity to AR/AO principles:

1) Agency commitment to anti-racism/anti-oppression
2) Anti-racism/anti-oppression training and professional development
3) Staff recruitment, hiring, and retention
4) Staff engagement and voice
5) Service user engagement and voice
6) Advocacy and community capacity building
7) Community engagement
8) Anti-racism/anti-oppression front line praxis
9) Holistic approach to health and well-being
10) Need/asset identification
11) Assessment of services
12) Appropriate, accessible and welcoming services

The AR/AO Fidelity Assessment Scale has **3 corresponding documents**:

a) The Assessment Guide
b) The Scoring Guide
c) The Scoring Booklet

The *Assessment Guide* outlines a rationale for each of the twelve criteria and details their constituent indicators. In addition, a glossary of terms used throughout the tool is provided as an appendix.

The *Scoring Guide* details instructions for data collection and scoring, including corresponding questions for service-users, service-providers, and senior management; this guide is meant for use by the individual or team completing the agency or organizational assessment.

The *Scoring Booklet* provides a method of tabulating scores for each criterion, as well as an overall score for agency or organizational fidelity to AR/AO practices; the scoring sheet is used in conjunction with the scoring guide.

ANTI-RACISM/ANTI-OPPRESSION EVALUATION CRITERION

CRITERION 1. AGENCY COMMITMENT TO ANTI-RACISM/ANTI-OPPRESSION

The agency has formalized its commitment to anti-racism/anti-oppression and is committed to effective implementation of anti-racism/anti-oppression practices.

RATIONALE

A management level person who has primary responsibility for AR/AO within the structure of the organization ensures that AR/AO will be addressed. Without a dedicated budget for AR/AO, only limited activities can be conducted. A written plan formalizes the agency's commitment to AR/AO. Review and updating ensures that the feedback loop has been closed and that corrective actions have been taken, as well as ensures the agency is able to respond to the changing characteristics of the target population.

INDICATORS

Agency Commitment to AR/AO	
1	Agency has not yet made AR/AO part of its mission;
2	Agency has made accountability for AR/AO part of at least one management level person's activities;
3	In addition to (2), agency has only one of the following: a dedicated budget for AR/AO activities; a written AR/AO plan with objectives, strategies, and implementation timetable;
4	Agency has both a dedicated budget for AR/AO activities and a written AR/AO plan with objectives, strategies, and implementation timetable;
5	In addition to (4), agency has been effectively monitoring and implementing its AR/AO plan /commitments.

Source: Adapted from Siegel et al. 2004

CRITERION 2. ANTI-RACISM/ANTI-OPPRESSION TRAINING AND PROFESSIONAL DEVELOPMENT

Agency offers to staff educational activities in which anti-racism or anti-oppression related issues are addressed and requires staff to have an adequate amount of specific training on anti-racism / anti-oppression.

RATIONALE

Training and educating staff in AR/AO enhances the likelihood that services will be delivered in anti-oppression, anti-racism competent environments. Ideally, educational activities should be available to all staff, and training should take place every year and be available to, if not required of, staff at all levels in the organization. Professional educational activities, when offered, should address equity issues and special considerations should be required for diverse cultural groups. This should be an explicit requirement of all guest speakers and course curricula. It is most crucial that all staff members who have face-to-face contact with and provide direct clinical care to agency service users receive AR/AO training. The three hours indicated must be focused on AR/AO issues. It is crucial that administrative staff also be knowledgeable about AR/AO issues.

INDICATORS

Anti-Racism/Anti-Oppression Training and Professional Development	
1	Agency does not offer educational activities in which anti-racism and anti-oppression issues are addressed, nor provides specific training on AR/AO to frontline staff and management;
2	Agency offers educational activities in which anti-racism and anti-oppression issues are addressed;
3	In addition to (2), agency *requires* all direct frontline staff and management to receive at least 3 hours of AR/AO training yearly;
4	In addition to (3), agency *requires* that administrative staff receive at least 3 hours of AR/AO training yearly AND orients all new staff on the agency's anti-racism and anti-oppression commitments and practices;
5	In addition to (4), agency *requires* all direct frontline staff and management receive 6 hours or more of AR/AO-relate training yearly.

Source: Adapted from Siegel et al. 2004

CRITERION 3. STAFF RECRUITMENT, HIRING AND RETENTION

Agency is committed to hiring and retaining staff that are representative of the community served.

RATIONALE

Having staff at all levels (direct service, supervisory and administrative) with relevant experience working with ethno-racial and disadvantaged groups enhances the likelihood of the acceptability and use of AR/AO practices. Hiring and retaining professional staff members who are from the ethno-racial backgrounds or have otherwise been part of a disadvantaged group (gender minority, sexual minorities, etc.) of service users provides positive role models for service users in the agency and affords additional opportunities to increase knowledge about the target population.

A word of caution: it has been noted that being from a culture or ethno-racial or otherwise disadvantaged group does not necessarily make an individual anti-racist/anti-oppression or culturally competent. While persons from the ethno-racial or disadvantaged group are most likely to be knowledgeable of relevant culture and power issues and their implications for service delivery to the group in question, AR/AO training or relevant experiences is still required.

INDICATORS

Staff Recruitment, Hiring, and Retention	
The agency has achieved the following benchmarks: (a) Recruitment and hiring procedures consider and assess AR/AO competency; (b) Frontline *and* management staff are reflective of the communities served; (c) Management and staff performance evaluation forms include items related to AR/AO; (d) Staff satisfaction and retention level data are reviewed taking into consideration racialized and marginalized group membership.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

CRITERION 4. STAFF ENGAGEMENT AND VOICE

Staff members are able to have their concerns heard by management and influence decision-making processes.

RATIONALE

Anti-racism/anti-oppression approaches are distinguished by their attention to issues of power and voice. Anti-racist and anti-oppression organizational practices as such should ensure that the voice of frontline service providers is welcome in organizational decision making and direction setting, and that power imbalances in the organizational hierarchy are acknowledged and addressed appropriately. Staff should feel safe in expressing their opinion and participating in decision-making.

INDICATORS

Staff Engagement and Voice	
The agency has achieved the following benchmarks: (a) A formal discrimination complaint mechanism in place for staff; (b) Created meaningful opportunities for frontline staff to be involved in organizational and program direction setting; (c) Established an accountability mechanism for addressing staff concerns and recommendations.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.

CRITERION 5. SERVICE USER ENGAGEMENT AND VOICE

Service users are able to have their concerns heard by management and influence decision-making processes.

RATIONALE

Anti-racism/anti-oppression approaches are distinguished by their attention to issues of power and voice. Anti-racist and anti-oppression organizational practices as such should ensure that the voice of historically disadvantaged and voiceless individuals and communities is welcome in organizational decision-making and direction setting. Power imbalances in the consumer-service provider relationship should be acknowledged and addressed appropriately such that consumers feel empowered in directing their care plan and in participating in organizational decision making/direction setting.

INDICATORS

Service User Engagement and Voice	
The agency has achieved the following benchmarks: (a) The agency has a formal discrimination complaint mechanism in place for service users; (b) The agency provides opportunities for program participants to be involved in agency/program direction setting; (c) The agency has a formal accountability mechanism addressing service user complaints and recommendations. (d) Service users feel that they are in control of their care and recovery planning at the agency.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

CRITERION 6. ADVOCACY AND COMMUNITY CAPACITY BUILDING

The agency is involved in advocacy-related and community capacity building activities that serve the interests, health and wellbeing of its racialized/disadvantaged service users.

RATIONALE

Anti-racist and anti-oppression approaches and analyses focus attention on inequitable social dynamics and power imbalances between groups. Anti-racism and Anti-oppression organizational practices should recognize that the processes of empowerment and disempowerment are rooted in societal and community practices. Such an approach to empowerment and health requires that communities are engaged and mobilized, and that systemic issues beyond the agency's immediate control are addressed through collaborative planning and advocacy efforts.

INDICATORS

Advocacy and Community Capacity Building	
The agency has achieved the following benchmarks: (a) Identified potential partners and stakeholders to better address needs of service users (optimized service delivery); (b) Formed alliances & partnerships with other anti-racist and/or anti-oppression organizations in the service area to build capacity and advocate more effectively; (c) Engaged in teaching and training of others in AR/AO principles and practices; (d) Engaged in social justice advocacy to change or influence legislation or institutional policies (beyond the agency) that negatively impact the health and well-being of racialized and/or disadvantaged service users.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

CRITERION 7. COMMUNITY ENGAGEMENT

The agency engages racialized and marginalized communities in the service areas to inform program planning and service delivery.

RATIONALE

Anti-racist and anti-oppression approaches and analyses focus attention on inequitable social dynamics and power relations between groups. Anti-racism and anti-oppression organizational practices should recognize the social and communal basis of not only disempowerment but also empowerment processes in addressing the health and well-being of service users. Effective engagement of service user communities by an agency is integral to better, more transparent care for service users, their families, and their carers. Engagement enables service users and target communities to work as partners with the agency in their care, and empowers communities to have a greater say in planning, design, delivery and evaluation of services.

INDICATORS

Community Engagement	
The agency has achieved the following benchmarks: (a) Communicated and disseminated program/service information to racialized/ disadvantaged communities in the service area; (b) Consulted with community members and organizations in the service area regarding their health-related concerns; (c) Actively engaged target communities in program / service planning; (d) Established mechanisms that allow accountable and transparent reporting to service users and community members regarding access pathways and recovery outcomes.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

CRITERION 8. ANTI-RACISM/ANTI-OPPRESSION FRONT LINE PRAXIS

Anti-Racism and anti-oppression inform and are put into practice at the direct service level.

RATIONALE

While focusing attention on structural and institutional determinants of health, anti-racist/anti-oppressive service delivery most directly impacts service users at the point of delivery. For this reason it is essential that anti-racism and anti-oppression theory is translated into frontline practice in ways that inform program/ service options as well as service delivery by front-line staff. This criterion is critical, as small acts of aggression based on race and/or oppression at the individual/interpersonal level are often the most insidiously hidden and can cause great harm.

INDICATORS

Anti-Racism/Anti-Oppression Front Line Praxis	
1	AR/AO in no way informs program staff direct service delivery to service users;
2	Program staff are aware of, and seek to minimize, power inequities in their relationships with service users and appreciate how their own cultural background and social location (race, class, gender, etc.) can impact upon relations with service users;
3	In addition to (2), program staff support service users to *identify, analyze* and *understand* how racism and oppression can find expression in health and social services, and how this, along with racism and oppression in the wider society, can detrimentally impact upon their *personal* health and well-being;
4	In addition to (3), program staff support service users to *strategize* how they might better cope with and challenge racism and oppression impacting their health and wellbeing;
5	In addition to (4), program staff supports service users to put anti-racism/anti-oppression healing strategies *into action*.

Source: Indicators adapted from Anne Bishop's 'Spiral Model of Learning' (*Breaking the Cycle of Oppression*, 1994), itself derived from the work of Paulo Freire in *Pedagogy of the Oppressed, 1970*.

CRITERION 9. HOLISTIC APPROACH TO HEALTH AND WELL-BEING

A holistic approach to health and wellness is adopted that informs program and service delivery.

RATIONALE

Holistic theory "recognizes and considers all aspects of human life – physical, mental, social, emotional, spiritual – as equally significant and interrelated" (Ocampo & Pinto 2013: 145-146). Anti-racist/anti-oppression programs and services are necessarily holistic, owing to their attention to racism, oppression and other determinants of health extending beyond immediate physical/biological factors, including (but not limited to) cultural, social, emotional and spiritual determinants of health.

INDICATORS

Holistic Approach to Health and Well-being	
The program supports the following functions: (a) Staff explore participants' views of wellness and illness; (b) Programs and services address and engage the families of service users, as desired; (c) A profile of social and cultural resources for ethno-racial and disadvantaged groups in the service area is maintained and made available to service users (e.g. houses of worship, community leaders, community-based organizations); (d) Agency provides access to alternative/complementary modes of healing (i.e. Ayurveda, yoga etc.).	
1	The program supports **zero** of these functions.
2	The program supports **one** of these functions.
3	The program supports **two** of these functions.
4	The program supports **three** of these functions.
5	The program supports **four** of these functions.

CRITERION 10. NEED/ASSET IDENTIFICATION

Needs and assets of service users and the target community are assessed to ensure effective service delivery from a strengths based perspective.

RATIONALE

Racism and oppression are characterized, among other things, by the overlooking of, and disregard for, the resources and resilience of racialized and disadvantaged individuals and communities. A critical ingredient of AR/AO service provision is determining both the needs and strengths /resources of individuals and communities. A strengths based perspective is rooted in the belief "that people are resilient, that they bounce back from life's adversities, despite what appear to be overwhelming odds" (Smith 2004: 16). Such a perspective allows for the recognition and celebration of communal and individual agency in the face of adversity.

INDICATORS

Need/Asset Identification	
The program supports the following functions: (a) Obtains current data on its service users that allows their service needs (including cultural, social and linguistic) to be identified; (b) Obtains current data on the target population that allows their service gaps (including cultural, social and linguistic) to be identified; (c) Annually collects and reviews current research regarding issues impacting the health of the target population and incorporates it into service planning and delivery; (d) Delivers services from a strengths based, recovery oriented perspective.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

CRITERION 11. ASSESSMENT OF SERVICES

The agency collects and reviews data on relevant health outcomes for service users.

RATIONALE

Racism and oppression are characterized, among other things, by the overlooking of, and disregard for, the needs, perspectives and experiences of racialized and minority community members. A critical ingredient of anti-racist and anti-oppressive service provision is evaluating and reporting outcomes and satisfaction with services to service users and the target population.

INDICATORS

Assessment of Services	
The agency has achieved the following benchmarks: (a) Annually collects and reviews disaggregated outcome data for services delivered; (b) Annually collects and review disaggregated data on service user satisfaction; (c) Uses data on service outcomes and user satisfaction to inform service planning and delivery.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.

CRITERION 12. APPROPRIATE, ACCESSIBLE AND WELCOMING SERVICES

Services are culturally appropriate and accessible to racialized and disadvantaged communities.

RATIONALE

A hallmark of racism and oppression is marginalization and erasure of the distinct needs of racialized/disadvantaged persons. Since mainstream services are often (wittingly or unwittingly) designed primarily with dominant groups in mind, it is essential that anti-racist and anti-oppressive service provision be specifically tailored to meet the unique needs and interests of racialized/disadvantaged community members. Anti-racist and anti-oppressive services are thus by definition necessarily both culturally and linguistically competent and physically welcoming. Providing a service environment that is welcoming and inclusive to racialized / disadvantaged communities is necessary to address experiences of exclusion and enhance notions of citizenship or belonging.

INDICATORS

Appropriate, Accessible and Welcoming Services	
The program supports the following functions: (a) Offers linguistically accessible programs and services; (b) Provides culturally appropriate programs and services; (c) Seeks to mitigate socio-economic barriers to participation in programs and services; (d) Offers a welcoming physical environment.	
1	The agency has achieved **zero** of these benchmarks.
2	The agency has achieved **one** of these benchmarks.
3	The agency has achieved **two** of these benchmarks.
4	The agency has achieved **three** of these benchmarks.
5	The agency has achieved **four** of these benchmarks.

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Appendix A: Glossary of Terms

Accountability for AR/AO: responsibility for documenting how AR/AO is part of the agency's activities.

Administrative staff: staff who hold decision-making and leadership roles but do not necessarily have direct contact with service users of the agency.

Alliances: informal partnerships and working relationships.

Alternative treatment/complementary therapy: this term is used to refer to healing services and forms that are not based on the traditional western health model. These may address emotional and spiritual wellbeing and/or social determinants of health and include various talking therapies. A (1995) British report by Sharon Jennings exploring the uses of complementary therapies in health settings provides three possible definitions of complementary therapies that are used here:

- Incorporating a broad range of therapies employing various methods but which have in common the promotion of the individual's own healing capacities;
- Sharing common principles such as using a broader definition of 'health' which not only represents the absence of symptoms but necessitates a spiritual well-being; working holistically with mind, body and spirit;
- Unscientific, unconventional, not medicine and linked to folklore (Jennings 1995:64; cited in Safe Haven Report 1998:66);

Some examples of this include Ayurveda medicine, aromatherapy, acupuncture, art therapy, music therapy or drumming therapy, herbal medicine, homeopathy, massage, naturopathic medicine, reflexology, Tai Chi, meditation, religious-based therapies and spiritual practices etc.

Anti-oppression (AO): a set of ideas that "taken together have the purpose of conveying and promoting sound practice that concerns the promotion and maintenance of equality, rights, equity, wellbeing, and independence through positive structural and personal initiatives" (Mallinson 1995: 67). Anti-oppression expands from "the narrow, exclusive focus on racial oppression to a broader, more inclusive understanding of the links between various forms and expressions of oppression" (Macey & Moxon 1996: 309).

Anti-racism (AR): an action-oriented approach to identifying and countering the production and reproduction of all forms of racism [including individual, institutional, internal, systemic, and cultural racism]. It addresses the issues of racism and the interlocking systems of social oppression. Anti-racism implies a goal of producing an understanding of what racism is and how it can be challenged" [*Source*: C. Tator, "Advancing the Ontario Human Rights Commission's Policy and Education Function" (2004) 3:3 Canadian Diversity 29 at 30].

AR/AO Training: agency-wide coordinated activity where staff members receive practical information on anti-racism and anti-oppression practice to improve service delivery to racialized and marginalized populations. The required 3 to 6 hours must explicitly focus on AR/AO approaches and issues.

Bilingual staff: staff members who have language capacity in both English and the specific non-English languages used by ethno-racial groups in the target community.

Community: refers to any group of people or organizations with a common local or regional interest in health, who shares a cultural background, history, or religion. These communities may be geographically dispersed but linked through an interest in relevant health issues.

Dedicated budget: funds needed for conducting AR/AO activities are available, although not necessarily explicitly identified as a budget line item.

Direct service/clinical staff: staff who provide clinical and support services (e.g., doctors, nurses, counsellors, social workers, case managers, community support workers).

Direction setting: this refers to decision-making processes concerning the agency's mission, mandate, values, vision, strategy, policy, and/or program planning and development. This may include, but is not reducible to, implementation issues and concerns.

Disaggregated data: information that is broken down into smaller subpopulations based on such characteristics as, but no limited to, country of origin within racial or ethnic categories, geographic locations, sex, gender, or socioeconomic status.

Educational activities: these include continuing medical/professional education courses, grand rounds, guest lectures, online courses, etc.

Ethno-racial: this includes racialized groups but also ethnic groups within racialized groups that may not be accounted for in the above definitions (e.g. Somali vs. Jamaican, though both may qualify as 'Black').

Goals to recruit, hire and retain: agency has documented (written) objectives regarding the desirability of having staffs who are from and/or who have previous experience working with the most prevalent ethno-racial/disadvantaged groups of service users.

Holistic Theory: Assumes that the whole person is motivated by their needs and that people have the potential to work towards psychological health, or self-actualize. Holistic theory considers all facets of human life including physical, emotional, social, spiritual; it furthermore recognizes that these areas are all important and interrelated.

Implementation timetable: a plan outlining when steps are to be implemented and completed and by whom.

Interpreter services: methods in place to assist persons with limited English proficiency. This includes telephone interpreter services ("language lines"), interpreters obtained from a central listing maintained by agency or other source, trained volunteers from target community with identified language skills.

Interpreters: individuals obtained from a central listing maintained by agency or other sources, trained volunteers from target community with identified language skills.

Key documents and forms: these include: consent to treat (which may be incorporated in insurance documents and billing information), release of information (including HIPAA), medication information (especially instructions and dangerous side effects), and rights and grievance procedures (which are often posted in a prominent place rather than distributed).

Management level person: an agency person who can effectuate change either by (i) the authority given to the position they hold by the agency director or executive board or (ii) direct line communication with agency decision makers.

Objectives: statements of what is to be achieved with respect to AR/AO.

Offers: agency either directly provides training or makes training available through an outside source and makes adjustments for staff to attend (time allowance and staff coverage, travel allowances and fees when needed).

Oppression: a system of domination that denies individuals dignity, human rights, social resources and power (Dominelli 2008: 10). This discrimination can include, but is not limited to: ableism, ageism, sexism, cissexism, heterosexism, genderism**,** racism, eurocentrism, xenophobia, anti-semitism, Islamophobia, and classism (for a complete treatment of anti-oppression terms see Canadian Race Relations Foundation "Glossary of Terms").

Orientation: activities or training provided to new staff members and administration at the beginning of their work tenure.

Outcome data: outcome measures should seek to assess the *impact* of participation in programs and services, in health service contexts, by assessing for and comparing health indicators before and after program/service use.

Partnerships: involve more formalized working relationships, including such things as written agreements.

Periodic review and updates: a requirement stating how often the plan is to be reviewed and updated.

Physical service environment: includes the agency's physical layout and presence of restricted spaces, as well as displays, pictures, posters, artwork and other decor.

Point of direct service: contact after the initial intake; point of first contact where a service is intended to treat a specified disorder.

Point of first contact: initial telephone inquiry (switchboard operator or automated telephone menu) or first visit to agency (receptionist/intake interviewer).

Prevalent ethno-racial groups of target community: use the following as a guideline for selecting ethno-racial groups with the greatest representation in the target community: an ethno-racial group that accounts for 5% or more of the population of a target community, or if less than 5%, contains at least 1000 individuals.

Racialized: racialized in this context is a term that is consistent with the Statistics Canada *employment equity* category of 'visible minority', which refers to 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' For statistical purposes, groups may be disaggregated along the following ethno-racial lines (following Statistics Canada categories):

- Aboriginal (Inuit, Métis, North American Indian)
- Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- Black (e.g., African, Haitian, Jamaican)
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- South Asian
- South East Asian
- White (Caucasian)
- Other

Racism: policies, practices, processes and/or representations and ways of thinking at the individual, institutional, systemic or cultural level that serve to unfairly exclude or disadvantage racialized persons.

Senior leadership: the highest level of leadership of an organization, e.g. the Executive Director.

Strategies: specific steps for achieving the named objectives.

Strength based perspective: a perspective rooted in the belief "that people are resilient, that they bounce back from life's adversities, despite what appear to be overwhelming odds" (Smith 2004: 16).

Suitable for ethno-racial groups: features of particular services that are understood by and acceptable to members of the most prevalent ethno-racial group, and that promote adherence to programmatic guidelines and improve engagement and retention.

Supervisory staff: service staff who are in decision-making positions and have overall responsibility for other frontline service staff.

Target community: a population the agency designates as its intention to serve. This can cover a population area (such as a geographically or politically defined service area) or a specifically targeted population (such as persons needing a specific type of intervention, persons in a certain age group, persons speaking a specific language).