camh

DISMANTLING
ANTI-BLACK
RACISM

A Strategy of **Fair & Just CAMH**

Prepared by the **Office of Health Equity** and the **Anti-Black Racism and Mental Health Advisory Committee**

Table of Contents

DISMANTLING ANTI-BLACK RACISM

A Message from
the President and the CEO

Systemic anti-Black racism is a barrier to high quality health care for Black patients—at CAMH and across the health care system. The data lay bare what those in Black communities have signalled for decades: discrimination and oppression based on race delays care and harms individuals on their way to recovery.

Racism also has a negative impact on the quality of work life for Black staff at CAMH. Beyond the damaging emotional and psychological consequences, it limits their career trajectory and precludes their ability to safely and fully participate in an environment where they can thrive.

This can't be tolerated. Black individuals and communities have a right to equitable access for high quality health care. CAMH staff have the right to a workplace that acknowledges and addresses this burden of inequity.

Our strategic plan, One CAMH, developed through more than 1,500 unique engagements with CAMH staff, patients and community members, identifies equity as a leading focus for our organization. The 22 targeted actions listed in the Dismantling Anti-Black Racism strategy will help us make progress that we can measure and track for improvement.

Thank you to the community of courageous advocates who are guiding our work toward barrier-free mental health care and a generative workplace; an environment that is safe for Black staff and holds opportunity for all to realize their personal and professional potential.

I want to recognize members of the Anti-Black Racism and Mental Health Advisory Committee for their dedication and partnership in developing this strategy. And thank you to the Black health care leaders who have contributed to our learning along the way.

CAMH has a lot of work to do. Our health care system was built on a foundation of racism. Dismantling the structures that uphold this foundation is a priority at CAMH. I hold myself directly responsible for this work, and fully accountable to Black staff and patients at CAMH.

I hope that our work can stand as a model of learning for system-wide change as we work together to eliminate anti-Black racism right here and right now.

Dr. Catherine Zahn
President & CEO
CAMH

A Message from the
Chairs of Fair & Just CAMH

It is with gratitude and hopefulness that we present CAMH's first strategy toward dismantling anti-Black racism. This strategy identifies key priority areas at the organizational, staff and clinical level, and **22 actions that aim to decrease anti-Black racism at CAMH by 2022**.

This strategy was developed in partnership with key community experts and with the guidance of the Anti-Black Racism and Mental Health Advisory Committee, an external group that offers support to CAMH's Office of Health Equity on dismantling anti-Black racism at the hospital. We owe them a deep debt of gratitude for their work and commitment in assisting us in building this document.

Growing evidence from Canadian studies and from our own analysis of CAMH data shows differences in the risk of mental illness and outcomes of care for Black populations. Unfair and unjust treatment has no place in our mental health system and CAMH is committed to ensuring that anti-Black racism is eliminated.

CAMH's strategy to dismantle anti-Black racism at our organization addresses issues that are systemic. CAMH will ensure that our staff has the right supports, training, tools and interventions to deliver equitable outcomes for Black patients and their families. CAMH will create an internal culture free of racism and oppression, where Black staff can thrive. CAMH will use its voice to advocate for better mental health and health equity for Black populations.

CAMH recognizes that collaboration and community voices are essential in dismantling anti-Black racism. Collaboration and community participation are core values of the strategy, along with a commitment to evidence-based service development and collaborative person-centred co-design of solutions.

This strategy is a focal point of the hospital-wide initiative, Fair & Just CAMH, and our strategic plan, One CAMH, reflecting a strong commitment to improve the mental health of Black communities. We recognize that dismantling anti-Black racism at CAMH and the health care system at large will take time. Although this document is our first strategy, it will not be our last. This is a living document that has 22 actions that aim to decrease anti-Black racism at CAMH by 2022. It will be revisited and built on over time to ensure its effectiveness and our commitment toward collaboration and ongoing learning. This strategy focuses on anti-Black racism. But it also recognizes that the roots of racism are different for Indigenous nations and Black communities, and that both communities are impacted by systemic oppression in institutions such as education, justice and health. Work must also be done to decolonize institutional systems of violence that continue to impact First Nations, Inuit and Métis.

Lori Spadorcia
Senior Vice President, Public Affairs,
Partnerships and Chief Strategy Officer
CAMH

Dr. Kwame McKenzie
Director of the Office of Health Equity
CAMH

Executive Summary

Across Ontario and at CAMH, oppression of and disadvantage against Black communities is evidenced by ongoing racial disparities in mental health and well-being. Black people in the Greater Toronto Area (GTA) are more likely to report poor mental health than people who are not Black, and Black people in Ontario are more likely to access mental health care through emergency or police services (Anderson et al., 2015b; Black Experience Project, 2017). In a recent analysis of CAMH data, rates of restraint use were 44 per cent higher among Black patients than among white patients. These disparities are real and demand our full attention and immediate action. Without addressing these disparities, CAMH's vision, Health redefined, cannot come to fruition.

At CAMH, this work fits within a hospital-wide initiative, Fair & Just CAMH, launched in 2019 with a commitment to advancing diversity, equity and inclusion. Action against anti-Black racism is a key focus in realizing a Fair & Just CAMH.

Dismantling Anti-Black Racism, a Strategy of Fair & Just CAMH, outlines priority areas focused on achieving results for patients and families, staff and for CAMH, and includes **22 actions that aim to decrease anti-Black racism at CAMH by 2022**.

This strategy provides a framework for the clear, measurable goals necessary to dismantle anti-Black racism at CAMH. It also highlights key partners, both internal and external, who are critical to achieving success.

The 22 actions included in this strategy are just the beginning. CAMH sees acting on these priorities as a vital step toward making strong progress in dismantling anti-Black racism at CAMH. However, CAMH recognizes that this list is not comprehensive and will evolve further as CAMH grows as an organization.

Anti-Black Racism and Mental Health Advisory Committee

Angela Robertson, Executive Director, Parkdale Queen West Community Health Centre

Asante Haughton, Peer Development and Training Manager, Stella's Place; Co-Founder, Reach Out Response Network; Member, CAMH Constituency Council

Dr. Notisha Massaquoi, Executive Director (retired), Women's Health in Women's Hands Community Health Centre (former committee member)

Paul Bailey, Interim Executive Director, Black Health Alliance

Sharon McLeod, Professor, Ryerson University

22 ACTIONS BY 2022

Priority Areas

RESULT 1 FOR PATIENTS AND FAMILIES

CARE FOR BLACK PATIENTS AND FAMILIES THAT IS SAFE, ACCESSIBLE AND EQUITABLE

Priority Area 1.1: Develop a system that can provide direct care and equitable outcomes for Black patients and families.

Priority Area 1.2: Enhance existing services to ensure they are successful for Black patients and families.

Priority Area 1.3: Review and revise clinical processes to reflect current best practices in delivering care to Black populations.

RESULT 2 FOR STAFF

AN EQUITABLE WORKING ENVIRONMENT FOR BLACK STAFF

Priority Area 2.1: Ensure a safe working environment at CAMH free from all forms of violence.

Priority Area 2.2: Improve the recruitment, retention and progression of Black staff at CAMH.

Priority Area 2.3: Develop, deploy and ensure uptake of training courses for staff and leadership that build capacity to create a better workplace environment for Black staff and care for Black patients.

RESULT 3 FOR CAMH

A MENTAL HEALTH SYSTEM, INSIDE AND OUTSIDE CAMH, WHICH AIMS TO ELIMINATE UNFAIR TREATMENT FOR BLACK POPULATIONS

Priority Area 3.1: CAMH will use its voice as a health system leader to help ensure equitable access to and improved outcomes of mental health treatment for Black populations.

Priority Area 3.2: CAMH will strengthen existing community partnerships and develop new meaningful relationships with organizations serving Black populations.

Priority Area 3.3: CAMH will develop, disseminate and implement best practices for research and data collection on mental health in Black populations.

CAMH Vision, Purpose, Mission, Belief, and Values

VISION   Health redefined.

PURPOSE   Position mental health at the centre of health care.

MISSION   We are dedicated to patient, family and community well-being. We improve access to integrated care, answer the most difficult questions about mental illness and remove barriers to belonging. Together, we choose hope.

BELIEF   Mental health is health.

VALUES   Courage, respect and excellence

DISMANTLING ANTI-BLACK RACISM

Background and Context

The goal of this strategy is to improve patient-centred health outcomes for Black patients at CAMH, and, as a partner and leader in system transformation, push toward a more equitable mental health system. Specific concerns about the quality of health care in Toronto's Black communities are not new. Community health centres, such as TAIBU and Women's Health in Women's Hands (WHIWH), were set up specifically to address inequities in access to and outcomes of care. The Black Health Alliance has been a community champion for the improvement of mental health services. At CAMH, both racialized and non-racialized staff have drawn attention to the unmet needs of Black patients. The Empowerment Council at CAMH has been advocating for improved health equity data to analyze the experiences of Black patients for years. Over the last decade, the catalysts for developing this strategy has been the work of health equity, and the concerns raised by the community and by staff.

ANTI-BLACK RACISM

Racism is an imposed system of structures, values and processes that serve to advantage one group over another. Race is a socially constructed way of categorizing humans based on physical characteristics and placing these categories within a hierarchy that suggests an inherent inferiority or superiority between different racial groups. In this way, racism continues to reinforce the concept of race. This hierarchy has no scientific validity and finds its genesis at a time when dehumanization was a strategy to advance imperial, patriarchal, heterosexist and settler-colonial interests through dispossession, enslavement, genocide and oppression.

There is a long history of anti-Black racism in Canada, and one example includes of the dehumanization and commodification of Black lives during the transatlantic slave trade. The slave trade depended on social relations that forced people of African descent to become intergenerational providers of free labour, thus subsidizing racial capitalism and imperialism. The intergenerational wealth and power of white people is one of the ways that anti-Black racism continues today. History requires us to recognize Black experiences with racism as uniquely different from other experiences with racism. These complex, reinforcing power structures have become embedded and reproduced in every facet of society and manifest in explicit and implicit forms of anti-Black racism that operate at individual, community and system levels. These ongoing manifestations of anti-Black racism result in very real and significant impacts on the lives of Black populations. Anti-Black racism increases the risk of mental illness because Black populations are more likely to be exposed to negative social circumstances, which lead to stress. There are significant systemic racial disparities in a number of social determinants, such as:

- **Income**: Almost 1 in 4 (24 per cent) of Black Ontarians qualify as "low income," as compared to 15 per cent of the general racialized Ontario population (Black Health Alliance, n.d.). Second-generation Black Canadians earn 10 to 15 per cent less than second-generation white Canadians, even when results are adjusted to reflect educational levels (Black Health Alliance, n.d.).

- **Education**: In the Toronto District School Board, 69 per cent of Black students graduated in 2011, as compared to 87 per cent of racialized students and 84 per cent of white students (Black Health Alliance, n.d.).

- **Social exclusion**: Black Canadians make up 9.5 per cent of the Canadian prison population, but represent only 2.5 per cent of the overall Canadian population (Black Health Alliance, n.d.).

- **Food security**: Black households are 3.56 times more likely to be food insecure than white households (Food Share, 2019).

Anti-Black racism is also a direct cause of psychological harm and trauma, which can have impacts similar to other forms of chronic violence (Carter, 2007).

ANTI-BLACK RACISM AND HEALTH CARE

IN ONTARIO

- Black populations in Ontario are more likely to report stress and poorer mental health than others, but show remarkable resilience in the face of social factors, which are known to increase the risks of mental illness (Black Experience Project, 2017).

- In Ontario, Caribbean immigrants have a 60 per cent higher risk of psychosis and refugees from East Africa have a 95 per cent higher risk of psychosis (Anderson et al., 2015a).

- Black Ontarians of Caribbean descent have a longer delay in receiving evidence-based services for psychosis than people of white European descent (Anderson et al., 2015b).

- Black Ontarians experience a higher level of aversive pathways to care (e.g., via emergency room, ambulance or police) than people of white European descent (Anderson et al., 2015b).

- Many innovative services, tools and interventions, such as culturally-adapted CBT, are shown to improve the health of Black populations in Ontario (Mental Health Commission of Canada, 2016), but they have not been scaled to meet the needs of Black populations.

- Despite the clear increased need for mental health supports in the face of adversity, Ontario spends less per person on the mental health of Black populations than white populations (Mental Health Commission of Canada, 2016).

A comprehensive picture of the disparities in access to and outcomes of care is challenging because full data sets do not exist. However, research reports and communities have identified a number of concerns, including:

• the competence of clinicians to offer equitable care

• barriers to care such as location of services and out-of-pocket expenses

• the cultural appropriateness of treatments

• fears of racial discrimination

• the links between mental health services and systems such as the police and child welfare.

Mental health services are often designed with biases inherent to western models of care that are rooted in colonial histories. Mental health professionals may also not have adequate training on cultural safety and anti-racism. These inherent biases and inadequate training hinder Black and other racialized populations from seeking care. Black patients' numerous, collective and ongoing experiences of racism within the mental health care system and by mental health service providers creates mistrust and fear. These experiences also further reduce the likelihood of Black people accessing services in the future. Racism thus creates a barrier to accessing mental health care.

AT CAMH

CAMH recognizes that gaps in data need to be addressed to provide a complete picture of racial disparities in outcomes and experiences. These data highlight and underscore the need for change in the mental health system and improved equity in CAMH services.

Important measures of quality in mental health care include admission rates to the hospital, who is readmitted within 30 days and rates of restraint (both when a patient is physically restrained or chemically sedated). Admission rates help identify who is in crisis and re-admission rates help identify when patients are not receiving appropriate follow-up care or have been discharged inappropriately. Many jurisdictions have seen a disparity in the use of restraints for Black patients compared with non-Black patients.

An initial assessment of patient data demonstrated high rates for admissions, re-admissions and restraints for Black patients compared to the average for CAMH patients. When differences in age, sex ratio and diagnosis were taken into account, there were no clear differences in admission and re-admission rates for Black patients compared to the average at CAMH. But restraint rates remained 22 per cent higher in Black patients than the average at CAMH, and 44 per cent higher than white patients. This shows evidence of a disparity in care outcomes for Black patients compared to other patients at CAMH.

Currently, socio-demographic data collection at CAMH is not fully comprehensive. However, the data available are able to shed a light on differences in treatment at CAMH for different groups.

Our Priorities:
Results CAMH Wants to Achieve

Launched in 2019, **Fair & Just CAMH** is a hospital-wide initiative committed to advancing diversity, equity and inclusion at CAMH. Fair & Just CAMH builds on recent initiatives for implementing cross-organizational change. It is a priority action within CAMH's strategic plan, One CAMH.

This strategy, which aims to dismantle anti-Black racism at CAMH, is part of the Fair & Just initiative, bringing together necessary changes at the organizational, staff and clinical levels.

RESULT 1
FOR PATIENTS AND FAMILIES

CARE FOR BLACK PATIENTS AND FAMILIES THAT IS SAFE, ACCESSIBLE AND EQUITABLE

RESULT 2
FOR STAFF

AN EQUITABLE WORKING ENVIRONMENT FOR BLACK STAFF

RESULT 3
FOR CAMH

A MENTAL HEALTH SYSTEM, INSIDE AND OUTSIDE CAMH, WHICH AIMS TO ELIMINATE UNFAIR TREATMENT FOR BLACK POPULATIONS
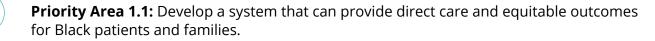
Actions

RESULT 1: FOR PATIENTS AND FAMILIES

CARE FOR BLACK PATIENTS AND FAMILIES THAT IS SAFE, ACCESSIBLE AND EQUITABLE

In order to achieve this goal, CAMH needs trained staff members who can deliver interventions that work for Black populations, in a system that allows equitable care.

Priority Area 1.1: Develop a system that can provide direct care and equitable outcomes for Black patients and families.

As a leader in mental health care, CAMH will ensure that its services are equitably accessible to Black populations. This requires a re-analysis of current pathways to care. CAMH will ensure that it has a model of service improvement that will help clinical teams offer better care to Black patients. Success in developing a system to provide equitable access and outcomes will require engagement with clinical teams, patients, communities, families and caregivers to inform planning of programs and services.

1 CAMH will assess its digital platforms and outreach, including Access CAMH, and develop a plan to promote equitable access to services. The launch of an enhanced referral management system in 2021–22 will be a key component of this plan.

2 CAMH will develop a model of service improvement for Black patients based on the Equity-Based Response Training pilot on its forensic units.

> **Partners: Anti-Black Racism and Mental Health Advisory Committee, Black Health Alliance, Clinical teams, Family and Patient Advisory, Empowerment Council, Access CAMH, Communications and Partnerships**

Priority Area 1.2: Enhance existing services to ensure they are successful for Black patients and families.

Mental health services based on principles of cultural safety and grounded in the lived experience of Black communities are more readily taken up by the community. For example,

in 2019–2020, Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) had a total of 1,413 visits, which was double the number of visits in 2015-2016. The partnership with WHIWH-CHC demonstrated an uptake of CA-CBT, which was successful because it was a community-led and context-specific service. Services such as SAPACCY and CA-CBT continue to be in high demand. Using this knowledge and creating new avenues for feedback from Black patients and families on what programs and services work for them will help the development of improved outcomes. Maximizing the availability of services we know work is an efficient step forward.

3 CAMH will train staff in culturally adapted CBT and increase access to culturally adapted CBT at CAMH.

4 All managers will take the Immigrant and Refugee Mental Health Course funded by Immigrant, Refugees and Citizenship Canada (IRCC).

5 CAMH will increase the staffing of SAPACCY to four full-time clinical staff and a manager.

Partners: Clinical teams, Education, Family and Patient Advisory, Empowerment Council, SAPACCY

Priority Area 1.3: Review and revise clinical processes to reflect current best practices in delivering care to Black populations.

Mainstream clinical services often do not consider the complexities of a diverse population. Many are rooted in western ethnocentric models that have been exclusionary and even harmful and violent to people who do not identify with the status quo. CAMH clinical processes and frameworks will reflect sensitive , complex and intersections of a patient's identity upon entering into care. For instance, tools such as clinical forms have been designed through the lens of inherent biases that make them exclusionary, oppressive, violent and unsafe. An Equity-Based Response Training pilot project in the forensic units will be implementing the cultural formulation interview in intake processes. Other clinical units will consider the findings and recommendations from this pilot. This is one example of how CAMH will reinvent processes with attention to anti-Blackness. Developing an evidence-based anti-Black racism impact assessment tool for mental health in partnership with community experts will aid this process.

6 CAMH will conduct a review to identify and analyze clinical processes where improvement and change is needed to better meet the needs of Black populations.

Partners: Professional practice, Quality improvement, Family and Patient Advisory

RESULT 2: FOR STAFF

AN EQUITABLE WORKING ENVIRONMENT FOR BLACK STAFF

In order to achieve this goal, CAMH needs to ensure it provides a safe environment and advancement opportunities to Black staff so that the workforce reflects communities that CAMH serves. This work should happen in consultation with the Anti-Black Racism Subcommittee of the Horizontal Violence, Anti-Racism, Anti-Oppression Working Group to ensure it is reflective of the needs of CAMH staff.

Priority Area 2.1:: Ensure a safe working environment at CAMH free from all forms of violence.

Prior to taking action and making changes, CAMH will create opportunities for Black staff members to feel safe to express their concerns and share their experiences of racism, oppression and horizontal violence. The organization will leverage the work of the Horizontal Violence, Anti-Racism, Anti-Oppression Working Group to assess the working environment at CAMH through surveys (such as the Horizontal Violence, Anti-Racism, Anti-Oppression Working Group survey), focus groups and interviews to document experiences of Black staff. These assessment measures will be conducted by external parties to ensure staff feel safe voicing their concerns. Drawing from the findings of these activities, CAMH will make actionable change such as the development of organizational policies including an anti-racism policy to better identify, address and prevent anti-Black racism and other forms of systemic oppression.

7 CAMH will develop a process to identify horizontal violence and other forms of racism, and to document and report incident rates.

8 CAMH's Horizontal Violence, Anti-Racism, Anti Oppression Working Group will develop a work plan to eliminate anti-Black racism through initiatives at CAMH.

9 CAMH will develop a support system for Black staff and a mechanism for confidential reporting of racist incidents.

Partners: People & Experience, Horizontal Violence, Anti-Racism, Anti-Oppression Working Group

Priority Area 2.2: Improve the recruitment, retention and progression of Black staff at CAMH.

CAMH will take a critical lens to current hiring and recruitment practices for physicians, staff, students and trainees. An implementation plan to respond to the recommendations of the People & Experience Talent Recruitment and Diversity Process Review will be developed and resourced immediately. Beyond recruitment, CAMH will create pathways of progression for Black staff. This will include the development of training and mentoring programs to support professional development opportunities for Black staff. CAMH's commitment to addressing anti-Black racism, pursuing equity and embedding principles of anti-oppression means that CAMH will also ensure staff and leadership are adhering to these values. Accountability policies and practices will consider measuring this commitment. One opportunity for this will be including mandatory diversity, equity and inclusion measures in performance evaluations.

10 CAMH will develop, implement and monitor a plan to improve the recruitment, retention and progression of Black physicians, staff, students and trainees.

11 CAMH will collect socio-demographic data on staff and will use this to measure progress on the diversity of its workforce and equality and inclusivity of its recruitment, retention and talent development practices.

Partners: People & Experience, Managers

Priority Area 2.3: Develop, deploy and ensure uptake of training courses for staff and leadership that build capacity to create a better workplace environment for Black staff and care for Black patients.

A workforce must be equipped with the tools and knowledge required to provide safe care to Black patients and a safe working environment for Black staff. Although training alone cannot solve the issues, it provides the groundwork required to build staff capacity, improve quality of care, and create a safer work environment. For example, the recently launched Equity-Based Response Training pilot project in the forensics units includes training on anti-Black racism, alongside key changes in clinical processes. A hospital-wide education strategy will be developed to identify equity-related training and education needs and opportunities. Such training will specifically address anti-Black racism, particularly within clinical settings, as well as highlight client stories, and employ an intersectional and anti-oppressive approach. Trainings will be tailored to different audiences (e.g., clinical team, research team, managers/leadership) and style of learners.

12 Staff will be trained in anti-Black racism, equity and cultural safety.

Partners: Education, Clinical teams, Managers

RESULT 2 FOR STAFF

RESULT 3: FOR CAMH

A MENTAL HEALTH SYSTEM, INSIDE AND OUTSIDE CAMH, WHICH AIMS TO ELIMINATE UNFAIR TREATMENT FOR BLACK POPULATIONS

In order to pursue the goals of this strategy, it is critical for CAMH to first build a supportive infrastructure from within and a mental health system outside that can deliver change.

CAMH leadership must acknowledge and address inequities experienced by Black patients and staff at CAMH. Leadership needs to make an active commitment to support the work of addressing anti-Black racism; specifically, to champion the immediate next steps put forth by this strategy. This leadership commitment must include investing in dedicated resources for this work and enhancing organizational infrastructure that will support the success of the strategy, such as new policies to explicitly address anti-Black racism. Leadership will do this by supporting the strategy, developing policies to address anti-Black racism at CAMH, and ensuring that the strategy is adequately resourced and linked to key performance indicators. These indicators will be reported on annually to the Board and the Anti-Black Racism and Mental Health Advisory Committee.

Priority Area 3.1: CAMH will use its voice as a health system leader to help ensure equitable access to and improved outcomes of mental health treatment for Black populations.

CAMH works with policy-makers and funders to implement new service approaches and helps guide the evolution of the mental health system. CAMH will use its leadership position to advocate for improvements in racial disparities in social determinants of health, access to services, and outcomes from treatment for Black populations. In addition, CAMH houses innovative programs such as SAPACCY, which can be modelled and delivered in community settings. Established in 1994, SAPACCY provides support and counselling to Black youth and their families who are dealing with mental health and addiction concerns.

13 CAMH will use its voice to advocate for better social conditions for Black populations in order to decrease the risk of mental illness and improve recovery rates.

14 CAMH will work with the Ontario Ministry of Health and Ontario Health to ensure equitable access to and uptake of appropriate structured psychotherapy for Ontario's Black populations.

15 CAMH will work with the Ontario Ministry of Health and the Mental Health and Addictions Centre of Excellence to ensure equitable access to and uptake of new child mental health services for Black populations.

16 CAMH will work with the Ontario Ministry of Health to develop mental health funding models that better meet the needs of Black populations in Ontario.

17 CAMH will work with the Ontario Ministry of Health and Ontario Health to secure funding for a community network of services similar to SAPACCY.

> **Partners:** CAMH Executive Leadership Team (ELT), CAMH Board, Provincial System Support Program (PSSP)

❯ **Priority Area 3.2:** CAMH will strengthen existing community partnerships and develop new meaningful relationships with organizations serving Black populations.

The formation of an Anti-Black Racism and Mental Health Advisory Committee is a positive step in advancing this work and the committee will provide oversight in the implementation of this strategy. Community expertise will be leveraged in the research, development and evaluation of services and clinical tools. Services designed by Black communities are more likely to result in positive outcomes for Black patients.

An example of successful collaboration is CAMH's partnership with Women's Health in Women's Hands Community Health Centre (WHIWH-CHC) to implement the use of culturally-adapted cognitive behavioural therapy (CA-CBT). After adding a part-time psychiatrist from CAMH to work at WHIWH-CHC, the number of WHIWH-CHC's clients who visited EDs for mental health problems dropped by about 45 per cent and dropped further by another 40 per cent when CA-CBT was added. CAMH has also partnered with the Black Health Alliance (BHA) to better understand community service integration and pathways to care for Black populations. CAMH is committed to advancing these partnerships and will find opportunities to continually work with and support Black communities.

18 CAMH will support the Black Health Alliance to implement Ontario-wide initiatives to improve pathways to care for Black populations.

19 CAMH will develop partnerships to help identify opportunities to streamline access to care including to improve clinical, education and information supports for primary and secondary care organizations whose work focuses on Black populations. These relationships will be modelled on the successful partnership with WHIWH-CHC.

> **Partners:** Anti-Black Racism and Mental Health Advisory Committee, Black Health Alliance, WHIWH-CHC, community partners serving Black populations, PSSP

RESULT 3 FOR CAMH

Priority Area 3.3: CAMH will develop, disseminate and implement best practices for research and data collection on mental health in Black populations.

Research is the foundation for evidence-based care. Part of this research includes collecting socio-demographic data to help CAMH identify and address disparities experienced by Black patients. CAMH will aim for 100 per cent socio-demographic data collection rates across all units, and will implement tools to capture similar data for all existing and new staff. The collection, storage and usage of these data will be in line with ethical protocols authored by Black researchers, academics and communities. The current gaps in research on mental health in Black populations must also be addressed. CAMH will prioritize this research and recruit Black researchers working in these areas to decrease research disparities. Similar to the guidelines on data collection, research involving Black populations will follow ethical protocols developed by Black communities. CAMH will also identify ways to support Black communities to lead, participate or partner in mental health research.

20 CAMH will report annually on the outcomes of care for Black people receiving treatment at the hospital.

21 CAMH will develop protocols to ensure that data collection and interpretation of data are grounded in evidence-based community principles.

22 Research at CAMH will develop and implement a plan to improve research on Black mental health, including how it will build its research capacity; train all staff on the impact of anti-Black racism on research design and methods; improve the quality of its research; and clearly articulate its accountability and governance of socio-demographic data.

Partners: Quality Improvement, Research, Performance Improvement

RESULT 3 FOR CAMH

Appendix

TERMINOLOGY

Access
Includes the right, permission, liberty or ability to enter, approach, communicate with or pass to or from; freedom or ability to obtain, to make use of; the action of going to or reaching; and increase by addition (American Heritage Dictionary, [1995] & Webster's Third International Dictionary, [1995]). Access to health services incorporates two aspects: client access – that is, the extent, to which clients are able to secure needed services, and organizational access – the extent to which diverse clients are represented and/or participate in the planning, development, delivery and administration of those services (Doyle & Visano, 1987).

Anti-Black racism
A systemic form of racism that intentionally and unintentionally harms people of African and Caribbean origin through systems and structures that exclude, silence, devalue and marginalize Black experiences. Anti-Black racism is rooted in the history and legacies of slavery and colonization and continues to uphold narratives of white superiority and Black inferiority thereby creating and reproducing prejudice, stereotypes and disadvantage for Black people (Black Health Alliance, n.d.; City of Toronto, 2017)

Anti-oppression
An interdisciplinary theory and praxis that demands reflexive practice to recognize systems of inequity that exist in society and to actively work to redress these power imbalances. Anti-oppression provides strategies and tactics to actively dismantle systems of privilege and oppression so that all members of society, regardless of their social location or multiple, intersecting identities, can have the same opportunities to reach their full potential in every aspect of life. This includes feminist, structural, anti-racist, radical approaches, perspectives and theories. Anti-oppressive practice has a social justice, equity, human rights perspective in the work and ways of seeing clients (Corneau & Stergiopoulos, 2012; Larson, 2008; Sakamoto, 2007)

Anti-racism
An active and conscious choice that can be taken by anyone to challenge ideological, individual and systemic/institutional racism. It translates into resisting and fighting all forms of oppression against racialized people (Zine 2004) and a move forward towards an egalitarian society that is free of ideological, systemic/institutional and individual racism.

Bias

Bias refers to being for or against something or someone. A value placed on something or someone being better than something or someone else based on partial, one-sided information and/or experience. Individuals and/or groups may have biases towards or against other individuals and groups based on various social identities such as ethnicity, culture, religion, socio-economic status, sexual orientation, gender identity, political and philosophical worldviews, etc. Biases are learned through social context within families, cultures, religions/spiritualties/secularism, ideologies and societal contexts. Often individuals and/or groups look for evidence that support their biases for or against something or someone (Dictionary.com, 2016; Merriam-Webster Dictionaries, 2016; Haselton, & Andrews, 2005).

Cultural safety

A term coined by Maori scholars as a reflection of the role of self-determination and decolonization in health care (NAHO, 2006). "Cultural safety within an Indigenous context means that the educator/practitioner/professional, whether Indigenous or not, can communicate competently with a [client] in that [client's] social, political, linguistic, economic and spiritual realm... that health care providers be respectful of nationality, culture, age, sex, political and religious beliefs, and sexual orientation . . . [and] the health care provider [recognizes] as bringing his or her own culture and attitudes to the relationship" (Van Gaalen et al., 2009, pp.11).

Decolonization

Decolonization once viewed as the formal process of handing over the instruments of government, is now recognized as a process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power (McDonough, 2013).

Discrimination

The actions, decisions and/or treatment for or against a person based on the perceived or actual membership to a group or category the person belong to. Discrimination is the actions, decision and/or treatment taken by an individual, group, institution or society that treats an individual and/or group negatively and involves the unequal treatment and unfair allocation of resources to individuals and/or groups who are being discriminated against. Discrimination can be based on accent, age, class/socio-economic status, disabilities, ethnicity, gender identity, language, physical and/or mental abilities, race, religion/spirituality/atheism, sex, sexual orientation, etc. Discrimination results in inequality, subordination, denial and/or removal of rights and freedoms of individuals and/or groups (Dictionary.com, 2016; Cambridge dictionaries, 2016).

Disparities

Avoidable and unfair inequalities experienced by disadvantaged social groups because of systemic forms of oppression that create and reproduce benefit for socially advantaged groups (Braveman, 2006).

Diversity

Diversity in its broadest sense means variety and difference. There is nothing inherently "good" or "bad" about difference. It is the values and meanings we place on them and the actions taken based on those values and means that becomes important. We are all diverse. Some key diverse identities including age, class/socio-economic status, disabilities, education level and background, ethnicity, gender identity, language/accent, physical and/or mental abilities, race, religion/spirituality/atheism, sex, sexual orientation, etc. (Merriam-Webster Dictionaries, 2016; Dictionary.com, 2016).

Evidence-based practice

Evidence-based practice involves the conscientious, explicit and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery. This requires that psychologists apply their knowledge of the best available research in the context of specific client characteristics, cultural backgrounds, and treatment preferences (CPA, 2012).

Equality

Every person enjoys the same status, and thus everyone should be treated the same way so that everyone can realize their full human rights and potential in contributing to social development, and then benefit from the results (Zine, 2004).

Equity

The process of being fair to everyone, which often requires designing particular measures to compensate for historical and social disadvantages that keep different groups at different levels. Equity acknowledges the fact that equal treatment for everyone does not always yield equal results for everyone (Zine, 2004). Equity refers to the rights of individuals and groups to an equitable share of the resources and influence in society. Equity means equitable access and outcomes. Equity work challenges unfair systems and practices and works towards the creation of equitable outcomes (Lopez & Thomas, 2006).

Ethnicity

A sense of identity based on a shared social history, language, geographical, religious, racial and cultural heritage. Everyone belongs to at least one ethnic group, which is inherited through our birth parents. (Oxford dictionaries, 2016; People & Bailey, 2010).

Health inequities or disparities

Differences in the health outcomes, of specific populations that are "systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill" (Whitehead, 1992). Different populations have inequitable access and use of the health care system. Research has shown that these inequities have been linked to social, economic, cultural, political and environmental inequities experienced by various populations. These social, economic, cultural, political and environmental factors are also defined as social determinants of health.

Health equity
The ideal state in which all people are able to reach their full health potential and receive high-quality care that is fair and appropriate from each person's perspective, no matter where they live, who they are or what they have (Health Quality Ontario, 2016).

Health system
The health system comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health (WHO, 2000).

Horizontal violence
A behavior that is directed by one peer toward another that harms, disrespects, and devalues the worth of the recipient while denying them their basic human rights (Purpora & Blegen, 2012 in CAMH's Horizontal Violence, Anti-Racism, Anti-Oppression Working Group Terms of Reference).

Inclusion and inclusive practice
Providing equal opportunity to all people to fully engage themselves in creating an environment and a cultural attitude whereby everyone and every group fits, feels accepted, has value, and is supported by a foundation built on trust and mutual respect (Wright, 2019). Inclusive practice entails the inclusion of diverse communities, values, beliefs, assumptions and practices in delivering health care services, hiring staff, forming partnerships and providing leadership. An example of inclusive practice is to make health care information and services available in a variety of languages (Williams, 2001).

Intersectionality
The term intersectionality comes from a critical legal theorist (Kimberlé Williams Crenshaw) explanation in 1989 of how attempting to understand the causes of "race" and gender oppression of Black women is like attempting to piece together the causes of an injury that occurs in an intersection with traffic flowing in many directions. Intersectionality means taking into consideration all the factors that structure identities and experiences of oppression (gender, race and ethnicity, class and social status, sexuality, physical abilities, age, residency/ nation/immigrant status, etc.). (Crenshaw, K., 1990; Carastathis, 2008).

Intersectionality also shows how systems of power interlock. For example colonialism and imperialism in other parts of the world shapes patterns, relations and oppression of live in caregivers, migrant workers, refugee policies, etc. in Canada now and through history" (Carastathis, 2008; Walia, 2006).

Several authors warn against "Oppression Olympics" a hierarchy or competition among categories of oppression to determine which is the worst/has the most impact (Martinez, 1993; Fellows & Razack, 1998 in Carastathis, 2008). An individual "does not possess a one-dimensional identity" but is "socialized into categories of race, gender and class" (Dei, 2000 p 31)." (Patychuk, 2011).

Marginalization

The social process of becoming or being made marginal (especially as a group within the larger society); "the marginalization of the underclass"; (www.thefreedictionary.com/marginalisation). Marginalized groups refer to groups of people who have historically been discriminated against, oppressed and/or stigmatized. Marginalization is an outcome of oppression.

Microaggressions

A term coined in 1970 by Chester Pierce, an African-American psychiatrist, to describe multiple small insults and indignities directed at people (Pierce, 1970). These can be commonplace, subtle and covert behaviors, comments or actions that communicate biases, prejudice and/or stereotypes about a group. Microaggressions can be conscious or unconscious, verbal (e.g., insults) or nonverbal (e.g., being ignored or excluded), and usually go unnoticed by members of the majority group because they are not explicit. Microaggressions are often not recognized as experiences of racism and therefore are committed regularly, repetitively, and often go unaddressed without consequence (Risser, 2008).

Oppression

When one social group exploits another for its own benefit; it results in privilege for the dominant group and disenfranchisement for the subordinated group. Oppression is systematically achieved through social control of institutions, cultural ideologies and norms of superiority and inferiority, distribution of resources and force. One characteristic of oppression is that over time it can appear to be a "normal" or predetermined state of affairs (Bishop, 2002; Charlton, 2000; Sakamoto, 2007).

Race

A socially constructed concept used to divide humans into categories according to a set of common visible traits (skin colour, shapes of eyes, nose or face); it is not based on genetics, biology or science. This category was developed based on 18th and 19th century Eurocentric ideology of white superiority and was used to exert European dominance through enslavement, colonialism and imperialism. While race does not produce racism, racism continues to reinforce the concept of race (Ontario Human Rights Commission, 2005; McDade, 2001; Satcher, 2001).

Racial capitalism

The idea that racialized exploitation and capital accumulation are mutually constitutive. Racial capitalism created the modern world system, through slavery, colonialism, and genocide because "the development, organization, and expansion of capitalist society pursued essentially racial directions so too did social ideology" (Robinson, 1983).

Racialized

Racialized is "the process by which societies construct race as real, different and unequal in ways that matter to economic, political and social life" (Commission on Systemic Racism in the Ontario Criminal Justice System, 1995). The terms "racialized group" and "racialized person" expresses race as a social construct rather than as a description of perceived biological traits (Ontario Human Rights Commission, 2005).

Racism

The systemic and institutional use of power within a society to deny rights and freedoms of individuals and groups based on their race. Racism is based on the prejudice, stereotyping and discrimination of individuals and groups who are seen as second class citizens or to be less than human. Laws, education and social values and practices are used to maintain racism. It is premised on the idea that humans can be ranked and divided into subgroups and that each subgroup can be ranked as inferior or superior. Racism can apply at an individual, institutional and at societal level. Because of the history and legacy of enslavement, colonialism/imperialism and eurocentrism, white people, culture and societies are perceived to be the standard that all other people, cultures and societies are compared to (Ontario Human Rights Commission, 2016; Garner, 2009; Newman, 2012).

Restraint

Among those clients/patients whom CAMH treats are individuals who experience some of the most acute mental health disorders in the health care system. Some of our patients have behavioural problems connected with their illnesses. Aggressive or violent behavior can present a risk of bodily harm to the client themselves or to others, and CAMH is responsible for maintaining a safe environment for everyone. Restraints are only used as a last resort after alternative, less restrictive measures and de-escalation strategies have been implemented and assessed as not effective. Restraints can mean mechanical, chemical, or environmental (also known as seclusion) (Use of Restraint at CAMH, 2008).

Systemic racism

Implicit and mostly invisible, systemic racism is embedded in the policies and practices of institutions and organizations. Systemic racism operates directly or indirectly to sustain the power structures and advantages enjoyed by the dominant groups. It results in the unequal distribution of economic, social and political resources and rewards among different "racial" groups. It also denies racialized people access to fully participate in society and creates barriers to education, employment, housing and other services available to the dominant group (Ontario Human Rights Commission, 2016).

REFERENCES

Black Health Alliance. Anti-Black racism. Available: https://blackhealthalliance.ca/home/antiblack-racism/. Accessed August 22, 2020.

Braveman, P. (2006). Health disparities and health equity: concepts and measurement. *Annual Review Public Health*, 27, 167-194.

Cambridge Dictionaries. (2016). Discrimination. Available: http://dictionary.cambridge.org/dictionary/english/discrimination?a=american-english. Accessed October 17, 2016.

Canadian Psychological Association. (2012). *Evidence-based practice of psychological treatments: A Canadian perspective*. Available: https://cpa.ca/docs/File/Practice/Report_of_the_EBP_Task_Force_FINAL_Board_Approved_2012.pdf

Carastathis, A. (2008). The invisibility of privilege: A critique of intersectional models of identity. *Ethics Forum*, 3(2), 23–38.

Charlton, J. I. (2000). *Nothing about us without us: Disability oppression and empowerment*. University of California Press.

City of Toronto (2017). Action Plan to Confront Anti-Black Racism.
Available: https://www.toronto.ca/legdocs/mmis/2017/ex/bgrd/backgroundfile-109126.pdf.
Accessed August 22, 2020.

Commission on Systemic Racism in the Ontario Criminal Justice System. (1995). Report of the Commission on Systemic Racism in the Ontario Criminal Justice System. Toronto: Queen's Printer for Ontario.

Corneau, S., & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry*, 49(2), 261-282.

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford Law Review, 43, 1241.

Dei, G.J.S. (2000). Towards an anti-racism discursive framework. In G.J.S. Dei & A. Calliste (Eds.), *Power, knowledge and anti-racism education*. Fernwood.

Dictionary.com. (2016). Bias. Available: http://www.dictionary.com/browse/bias. Accessed October 17, 2016
---- (2016). Discrimination. Available: http://www.dictionary.com/browse/discrimination. Accessed October 17, 2016
---- (2016). Diversity. Available: http://www.dictionary.com/browse/diversity. Accessed October 17, 2016.

Doyle, R., Visano, L. A., & Giovannini, M. (1987). *A Time for Action!: Access to Health and Social*

Services for Members of Diverse Cultural and Racial Groups in Metropolitan Toronto. Social Planning Council of Metropolitan Toronto.

Fellows, M. L., & Razack, S. (1997). The race to innocence: Confronting hierarchical relations among women. *The Journal of Gender, Race & Justice, 1*.

Free Dictionary. (n.d.). Marginalisation. Available: http://www.thefreedictionary.com/marginali-sation. Accessed October 17, 2016.

Garner, S. (2009). Racisms: An Introduction. Sage.

Haselton, M. G., Nettle, D., & Andrews, P. W. (2005). The evolution of cognitive bias. In D. M. Buss (Ed.), *The Handbook of Evolutionary Psychology*. John Wiley & Sons Inc.

Health Quality Ontario. (2016). *Better has no limit: Partnering for a quality health system*. Ministry of Health and Long Term Care. Available: http://www.hqontario.ca/Portals/0/documents/about/strategic-plan-2016-en.pdf. Accessed October 17, 2016.

Larson, G. (2008). Anti-oppressive practice in mental health. *Journal of Progressive Human Services, 19*(1), 39-54.

Lopez, T. & Thomas, B. (2006). Dancing on Live Embers. Toronto: Between the Lines.

Martinez, E. (1993). Beyond black/white: The racisms of our times. *Social Justice, 20*(1/2).

McDade, W. A. (2001). The despair of health disparities. *Virtual Mentor: Promoting the Ethics and Professionalism of Tomorrow's Physicians, 3*(6).

McDonough, S. (2013). Decolonizing Methodologies: Research and Indigenous Peoples by Linda Tuhiwai Smith. *Collaborative Anthropologies, 6*(1), 458-464.

Merriam-Webster Dictionaries. (2016). Bias. Available: http://www.merriamwebster.com/dictionary/bias. Accessed October 17, 2016.
---- (2016). Diversity. Available: http://www.merriam-webster.com/dictionary/diversity. Accessed October 17, 2016.

National Aboriginal Health Organization. (2006). Fact sheet: Cultural safety. Available: https://fnim.sehc.com/getmedia/c1ef783b-520a-44cf-a7b8-d40df5e406e7/Cultural-Safe-ty-Fact-Sheet.pdf.aspx?ext=.pdf . Accessed January 24, 2020.

Newman, D. M. (2012). Sociology: exploring the architecture of everyday life (9th ed.). Los Angeles: SAGE.

Ontario Human Rights Commission. (2016). *Racial discrimination, race and racism (fact sheet)*. Available: http://www.ohrc.on.ca/en/racial-discrimination-race-and-racism-fact-sheet. Accessed October 17, 2016.

---- (2016). *Racism and racial discrimination: Systemic discrimination (fact sheet)*. Available: http://www.ohrc.on.ca/en/racism-and-racial-discrimination-systemic-discrimination-fact-sheet. Accessed October 17, 2016

---- (2005). *Policy and Guidelines on Racism and Racial Discrimination*. Available: www.ohrc.on.ca/en/policy-and-guidelines-racism-and-racial-discrimination. Accessed October 17, 2016.

Oxford dictionaries. (2016). Ethnicity. Available: http://www.oxforddictionaries.com/definition/english/ethnicity?q=ethnicity. Accessed October 17, 2016.

Patychuk, D. (2011). Health equity and racialized groups: a literature review. *Health Equity Council*.

People, J. & Bailey, G. (2010). Humanity: An introduction to cultural anthropology (9th ed.). Wadsworth Publishing.

Pierce, C. M. (1970). Black psychiatry one year after Miami. *Journal of the National Medical Association, 62*, 471–473.

Purpora, C., & Blegen, M. A. (2012). Horizontal violence and the quality and safety of patient care: a conceptual model. *Nursing Research and Practice, 2012*.

Risser, P. (2008, May 14). *Trauma Informed Case Management*. 4th Annual Clinical Forum on Mental Health: Turning Knowledge into Practice. Available: https://player.slideplayer.com/15/4550259/#. Accessed October 17, 2016.

Robinson, C. (1983). Black Marxism: The making of the black radical tradition. University of North Carolina Press.

Sakamoto, I. (2007). An anti-oppressive approach to cultural competence. *Canadian Social Work Review, 24*(1), 105-114.

Satcher, D. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. US Department of Health and Human Services.

Use of Restraint at CAMH: Questions & Answers. (2008, September 10). Available: http://insite.camh.net/files/sep08_restraintsqa_38720.pdf. Accessed January 10, 2021.

Van Gaalen, R.P., Wiebe, P.K., Langlois, K. & Coste, E. (2009). Reflections on mental wellness in First Nations and Inuit communities. In Mentally Healthy Communities: Aboriginal Perspectives. Ottawa: Canadian Institute for Health Information. Available: https://secure.cihi.ca/free_products/mentally_healthy_communities_aboriginal_perspectives_e.pdf. Accessed October 17, 2016.

Walia, H. (2006). The new fortified world: Colonialism, capitalism, and the making of the apartheid system of migration in Canada. *New Socialist, May/June* (56).

Webster's Third International Dictionary (1995). *Access. American Heritage Dictionary 1995 & Webster Dictionary*.

Whitehead, M.M. (1992). The concepts and principles of equity and health. *International Journal of Health Services, 22*, 429–445.

Williams, C. (2001). Cultural competence skills for social service providers. Classroom course offered by Centre for Addiction and Mental Health and University of Toronto.

World Health Organization. (2000). *The world health report 2000: Health systems: Improving performance.* World Health Organization.

Wright, J.E. (2019). The language of inclusion. Available: https://dornsife.usc.edu/assets/sites/1/docs/The-Language-of-Inclusion-2019-Vol.2.pdf

Zine, J. (2004). Glossary of Terminology [Prepared for Sociology of Race and Ethnicity / Principles of Anti-Racism Education course, 2004–2005]. Toronto: Sociology and Equity Studies in Education, Ontario Institute for Studies in Education.