CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: March 3, 2021

COUNSEL: Allen Murray, QC, Inquiry Counsel
Shane Russell, Esq., Inquiry Counsel

Lori Ward and Melissa Grant,
Counsel for Attorney General of Canada

Glenn R. Anderson, QC, and Catherine Lunn
Counsel for Attorney General of Nova Scotia

Thomas M. Macdonald, Esq., and
Thomas Morehouse, Esq.
Counsel for Richard Borden, Thelma Borden and Sheldon Borden
Joint Counsel for Aaliyah Desmond

Tara Miller, QC,
Counsel for Estate of Brenda Desmond
(Chantel Desmond, Personal Representative)
Joint Counsel for Aaliyah Desmond

Adam Rodgers, Esq.
Counsel for Estate of Lionel Desmond
(Cassandra Desmond, Personal Representative)

Roderick (Rory) Rogers, QC, Karen Bennett-Clayton and Daniel MacKenzie,
Counsel for Nova Scotia Health Authority

Amy MacGregor
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

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DR. ISABELLE GAGNON

EXHIBIT LIST

March 3, 2021

COURT OPENED (09:32 HRS.)

THE COURT: Thank you. Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Good morning, Dr. Gagnon.

DR. GAGNON: Good morning, Your Honour.

THE COURT: Perhaps we could swear Dr. Gagnon before we begin then, please.

DR. ISABELLE GAGNON, sworn, testified:

THE COURT: Thank you, Dr. Gagnon, we appreciate you giving us your time for the day.

In the normal course of events we start at 9:30, we'll continue partway through the morning and it depends on the circumstances we take a short break sometime around 11:15 or maybe 11:30, and we break at 12:30 our time, be 11:30 your time I guess, for an hour for lunch and then we're back and try to have an afternoon break as well.

If you have difficulty hearing us or if you have difficulty with the video in any way just let us know, we have some limited ability to make some adjustments. And short of that, I think Mr. Russell may lead off the questions for you. Thank you.

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Dr. Gagnon.

A. Good morning, Mr. Russell.

Q. Hello again. So I guess if at any point I break up or you can't hear me, just sort of let us know and we'll take a break and ...

A. I will.

Q. ... make some re-adjustments. I guess we'll start. Could you state your full name for the Court?

A. Marie Louise Isabelle Gagnon.

Q. And my understanding is you're a clinical psychologist?

A. That's right.

EXHIBIT P-000253 - *CURRICULUM VITAE* OF DR. ISABELLE GAGNON

Q. So we'll start by reviewing your qualifications, it's Exhibit 253. It'll just take a minute to come up. Could you see that on the screen or ...

A. I can but a little bit bigger would be appreciated. Perfect.

Q. So, Doctor, I guess I'll start very briefly. It's not my intention to review everything in this document. We'll start with your education. So when did you receive your Doctorate of Psychology and from where?

A. In 2016, from the Universite du Quebec en Outaouais.

Q. And my understanding is ... what was your thesis?

A. So my thesis was assessing treatment for PTSD with comorbid substance use in a psychiatric setting. I was working with a supervisor in a multicultural trauma clinic.

Q. Could you tell us generally what that involved, PTSD and comorbid substance use disorder?

A. Sure. So the clients that we treated had a diagnosis both of PTSD and either one substance or multiple substances, such as alcohol, heroin, marijuana, any of those things. And so we used an approach that worked to treat both of these difficulties at the same time which is often considered a good practice to use.

Q. Okay. So from graduation, if we turn to page 2, it looks to be in April 2016, so as soon as you graduated ...

A. Yeah.

Q. ... to December 2016, where did you work?

A. So often for a Doctorate in Psychology, there's some delay from when you're done your schooling and paperwork comes in, so initially you can work as a doctoral candidate. So, initially I worked at the Centre de Therapie pour Couples and Familles, where I had both couples and individual clients, and then after that I went to Ste. Anne's.

Q. And approximately when did you go to Ste. Anne's?

A. I started ... there was somebody in my position beforehand that I started going to see I think at first it was once a week, just to have that turnover of information. I think

I started going ... I'd have to look at my documents, I think it was in February or March ...

Q. Of ...

A. ... to receive that information.

Q. Of 2016?

A. Of 2016, that's right.

Q. Okay. So what was your role when you were at Ste. Anne's in February or so of 2016 and what were some of your, I guess, duties as a clinical psychologist?

A. So at that point, having not received my doctorate yet, I was a doctoral candidate, just to be clear, so I was receiving a lot of information. I'd have again to review exactly when things shifted but I was receiving a lot of information from my predecessor, learning all the material for the different treatments that were offered, learning how the clinic worked, meeting all my colleagues and then, you know, starting to offer treatments at Ste. Anne's.

Q. So what sort of treatments did you ... I guess, at Ste. Anne's, what type of patients did you encounter and treat and diagnose?

A. Well, it is a clinic that's specifically mandated to offer treatment for operational stress injuries, so diagnosis-

wise a lot of post-traumatic stress disorder, some mood disorders, some anxiety disorders.

So there was an admissions committee that would look over files that were sent us to see if it was a good fit between people being referred to us and then the services we could offer. There are clinics in Canada that do residential treatment for substance use and PTSD, we did not. So the requirement was that somebody wasn't actively having a lot of difficulties with substance use while they were there. So that was one of the limits.

Q. Are you able to comment on what your caseload was like while you at Ste. Anne's in 2016?

A. It would depend on the clients that were coming in. We did a mix of individual therapy and group therapy, so I would typically ... and then some of my duties were also, for instance, to sit on the admissions committee, so I had both; kind of more administrative duties and clinical duties.

So I would usually have, again, if memory serves, something like three to four individual clients that I would follow in individual sessions, and then I believe I offered two different group therapies.

Q. And so you stayed at Ste. Anne's until December of

2016?

A. That's right.

Q. If we look to page 1 it says January 17th to present ... January 2017 to present. So where are ...

A. Mm-hmm.

Q. ... you currently employed?

A. I'm currently working at the National Defence OSI clinic for active military members at Montfort.

Q. So that is, you indicated, with active military members?

A. That's right.

Q. And are your duties very similar to what they were at Ste. Anne's?

A. Somewhat similar. Obviously in the current context I'm not offering group therapy anymore, but we did put in place group therapy which I did offer. I think I do a lot more regular assessments and I have a bigger caseload of individual clients, but fairly similar.

(09:40)

Q. And, again, it's treating members of the military with operational stress injuries, is that fair to say?

A. That's right. At the clinic there's different

sections and I am in the section that does deal specifically with operational stress injuries.

Q. And in your time between Ste. Anne's, starting in 2016, and your current employment, what sort of psychological disorders or symptoms did you diagnose and treat as a general rule?

A. A wide range. I can get into detail if you'd like, but, I mean, I think the expectation for clinical psychologists unless you're very narrowly into a field is to be able to treat most mood disorders, most anxiety disorders. In my case, with some of the training that I've had, post-traumatic stress disorder. Some individual had again, comorbid difficulties with personality disorders. In my time at my current work, people who have substance use disorder as well, so quite a wide variety.

Q. I see on your *CV* you have a number of specialized training in certain treatments and one is cognitive behavioural therapy.

A. Sure. So I'm a little picky when it comes to terms. I'm really careful when I use terms like "specialized". That would imply that I have somehow superior skill to anybody else that's trained to treat PTSD and I don't want to imply that.

CBT is a very well-respected, well documented, you know, truth be validated approach, which I am trained in. And then if you look at the training ... this is a summary, I'll be happy to provide ... this is the bare bones of the training that is expected of psychologists, that's a mandated continued education that we have as psychologists, but a prolonged exposure, for instance, the subset of cognitive behavioural therapy for PTSD.

Q. So you have experience in training in cognitive behavioural therapy, prolonged exposure therapy as examples?

A. Yeah, as examples. Yes.

Q. I guess, Doctor, we could spend more time on your *CV* but I'm going to move ahead to questions in general.

A. Sure.

Q. So given your professional experience since 2016 graduating, I just want you to maybe turn your mind to sort of any ... could you identify any barriers, challenges that come to mind when you're treating either active military members or military veterans as it relates to building a therapeutic alliance?

A. I have evolved most of my life in a military setting. My father was military. I have experience in the Reserves. My spouse has been deployed several times. So that hasn't been so

much a barrier for me but I know that one barrier that's been reported to me is when people struggle with lingo.

You know, if you are confiding in somebody in the things that have been very difficult during your career, that you've had very difficult experiences, but then you have to stop and break off and explain acronyms or kind of military terms, that can be a little bit off-putting. So that's something that I've heard from people that can be a little difficult.

Certainly I think I'm hearing from my active members right now that stigma I think is being gradually broken down, which I'm very happy to hear, but I think that especially probably in older members, this was something that was very difficult for them to overcome to access treatment. This perception that there was a negative connotation to having some mental health difficulties.

Q. Is there anything sort of unique or again, a barrier or a challenge, to trying to structure treatment goals as it applies to an active member of the military or a veteran?

A. I mean, radically different from a civilian population, I hesitate to say that. One thing I might mention is - again, this is not every military member - but often, you know, a military career for some people is seen almost as a

calling as opposed to just a job and so I think that it can be a little scary to leave the CAF and to think, Okay, well I kind of have to find some new values, some new ways of being, some new employment and really I think there's a sense of loss here, so that can be a little destabilizing I think, but I think anybody feels those type of things in major life transitions.

Q. And again in a military client-based context, are there any sort of unique barriers or challenges when it comes to sort of the implementation of treatment? Just in general terms again but ...

A. You know when it comes to ... and perhaps this is something that we'll get into, but OSI is a very kind of umbrella term that does encompass a number of diagnoses. But if we are talking specifically, for instance, of PTSD there are some kind of gold standard treatments that are recommended, whether it's a civilian or a military population so there wouldn't be any major changes there.

Maybe the only thing I would note is, you know, if people have been in operational settings, they're offered training to be excessively alert and prudent and vigilant about their surroundings, to scan for signs of danger and to monitor what's going on around them.

So I think maybe there's often that extra level of caution that needs to be broken down because it was very functional training that they received at the time, it's just not useful for them once they're back in a safer environment. So that could be a nuance that I would identify.

Q. You had referred to certain treatments as "gold standard treatments".

A. Mm-hmm.

Q. What are some examples of what you consider and have heard of as being gold standard treatments?

A. So they're often the treatments that are the most well studied and have good outcomes so I don't want to disparage any other treatments that are currently being studied and may, of course, reach those standards. But usually the standards that are that the treatments are considered when you're doing active trauma treatments and maybe I'll distinguish that one later, so EMDR, prolonged exposure, and then cognitive processing therapy are usually kind of considered those gold standards.

Q. Okay. And again in the context of military-based clients, barriers or challenges to the follow-up and sort of continuity of care, this sort of transition of hand-off from different groups of professionals, different clinics, this

ongoing treatment.

A. I think the challenges at Ste. Anne's were maybe a little bit more unique because we would get referrals from all over the country and so we talked to, you know, a really wide variety of treatment teams that were referring these members to us. So there were a lot of kind of developing new relationships for that back and forth of information.

Maybe I can just speak to where I'm working now, but in general I've had very little issues with that transition. You know, if I am treating a serving member who is in the process of releasing, you know, we get that date in advance, we'll set up care kind of on the other side. I'll do the transition of this member to somebody that is covered by VAC ahead of time, do kind of a little bit of parallel care and then when they transition it's not too much of an issue.

I think some of the issues come in when there's different locations, when people have like one last posting. Yeah, some of those things. I think that the challenges are a bit more kind of geographic maybe as opposed to ... Again, I can speak to where I am right now, I haven't had any major kind of challenges.

Q. Okay. And I know you're reluctant to say a

psychologist that primarily operates in a military context is sort of a sub-specialist in psychology, but would you say that there are some advantages, I guess, to a clinical psychologist ... When a clinical psychologist treats a member of the military or former member of the military, is there an advantage to having the experience dealing with those based clients as opposed to not ever having experience treating clients with a military background?

A. Sure. I think that when you're treating any kind of ... I think I would look at this almost as a cultural knowledge. You know, if I'm treating ... if I start treating police officers at some point, I'm going to want to know, you know, lingo. I'm going to want to know, you know, what their specific issues are.

(09:50)

And so when I register with my College, I have to identify what my areas of competencies are, right, and I think that's a little bit what you're alluding to. So I'll say I'm working with adults or children. And I can't suddenly one day decide I'm going to start working with kids, that's a vastly different field. Not so, necessarily, with working with ... If I have competence in PTSD, it wouldn't be a radical shift then to treat

somebody that has PTSD that's in the military.

I think it would be my job as a psychologist to inform myself, do some reading about, you know, particular issues, and then perhaps even be kind of transparent with my client and say, Listen, I have the competences to treat, you know, what you're suffering as a disorder, but you're going to have to work with me and be a little bit patient while I learn the lingo.

I don't think that psychologists or social workers or anybody can be expected to know everything, and I think that any, you know, therapeutic relationship is based on this kind of give and take of tell me what's going on for you and I'll try to understand, so ...

Q. So I guess this sort of concept of ... what we understand is that it takes time and it can vary to build a therapeutic alliance and the importance of that.

A. Yeah.

Q. Would it be easier for a clinical psychologist to build that rapport with a patient if they have some sort of understanding at the outset of the military culture where the client is coming from?

A. I would expect that to be part of the process. If you do not, I would expect the person treating this person to be

sensitive to those kind of concerns and to learn. Everybody has got to learn at some point. And I would say even if you have competences within kind of military there are different trades in the military, you know, different deployments and different challenges. And I'm ... every time I have somebody that's in a new trade or has had a different deployment I learn new things. So it's a never-ending kind of road to make sure that you have the required information. So I don't think it's a black or white issue.

Q. Okay. I'm going to turn to the structure of Ste. Anne's. We heard a bit ...

A. Okay.

Q. ... from Dr. Ouellette, quite a bit from Dr. Ouellette yesterday especially as it relates to the stabilization program and how clients move from stabilization to the residential phase of the program.

I'd like to start, I guess, by asking: You were the clinical coordinator for Lionel Desmond while he was at the residential phase of Ste. Anne's, correct?

A. Mm-hmm. I was the clinical coordinator for the clinic.

Q. For the clinic. Could you tell us what your role was as the clinical coordinator for the residential phase of the

clinic?

A. So I was the clinical coordinator for just the clinic in general, both ...

Q. Okay, sorry.

A. ... stabilization and residential, there's no ... it's okay. So there's ... just there's no distinction. So it's a little bit of those extra administrative duties that I had mentioned: sitting on the ... well, I guess it's not totally administrative ... administrative and clinical duties. Like sitting on the admissions committee and giving my opinion about some challenges, some extra information that we would need. Reviewing some of the treatments that we were offering, so sitting on our kind of interdisciplinary meetings and trying to kind of manage those. Some of the notes that you've seen in Mr. Desmond's file with regards to if there were conflicts or specific challenges. Sometimes we would meet individual residents and then I would usually be on those meetings, so some of those types of duties.

Q. So is it fair to say, say in Lionel Desmond's case, you're a clinical coordinator, was part of your role to pull in social work, pull in occupational therapist, pull in psychiatry, structure those meetings and have sort of a collaborative care

model?

A. Yeah, that was a matter of course for every client, yes.

Q. Okay. And that's one of the roles, I guess, as a clinical coordinator is to sort of to steer a collaborative care model within that Ste. Anne's structure?

A. Certainly to facilitate it. It's definitely not an authoritative or power structure, but definitely to try to facilitate those things.

Q. All right. And so as a rule, how long is the ... I can appreciate it can probably vary, but how long is a residential phase when a client is at the Ste. Anne's program on the long end of things and on the short of things?

A. So - and I apologize in advance, it is four years ago so some ... I tried to refresh my memory by looking at my notes but some details will probably be a little vague for me - from memory, I believe that the residential phase was a little bit more stable in terms of duration, so it was around eight weeks.

Q. Okay. And during the residential phase, could you give us a sense of the client that is there, such as Lionel Desmond that's being treated for PTSD, major depressant dis- ... depression, as well as comorbid alcohol use in remission and of

course mixed personality traits, what sort of resources from healthcare professionals does he have access to?

So what types of healthcare professionals would sort of operate in that circle of care for someone like Lionel Desmond while at the residential phase?

A. So the residential phase is a little bit more focussed on that, the group aspect. So again if memory serves, you know, I was offering some group treatment, so a psychologist. Some social workers were also offering some group treatments again if I'm not mistaken. I believe they still had access to a physical trainer. I believe an occupational therapist, a yoga teacher, nurses to manage kind of how they were doing. Again, if memory serves, medication taking at that point is autonomous, so the access to nurses is more to deal with issues. So pretty much the whole range of professionals.

Psychiatrists have usually taken a step back in the residential phase, but again, from what I remember if there is a specific need we can always call on them.

Q. Is there ... that certainly seems to be sort of a collaborative care being offered. Is that correct?

A. Yeah, that's right.

Q. What is the advantage to, say, a veteran at Ste.

Anne's getting that collaborate care model as opposed to, Look, I have one therapist and I see a psychiatrist every so often.

A. So there's multiple reasons why somebody's external treatment team might decide that somebody would benefit from this type of treatment. Often it is people being in situations where they become sometimes quite depressed, having trouble getting out, socializing, engaging in any kind of activity. So a lot of the focus at Ste. Anne's was on this stabilization piece to try to get people to build up their skills to go back into their previous treatment team and receive a little bit more kind of trauma-focussed care.

So I think that the upside of having collaborate care is when one of us would identify a specific issue, you know, depression and lack of activity, well then everybody could work some of those interventions from their aspects, their kind of professional lens to try to really build up skills and build up abilities in that specific area.

Q. Is it fair to say that ... Obviously you know Lionel Desmond's underlying psychological difficulties and struggles. Is it fair to say that one professional, say if it would be one social worker, couldn't really possibly treat everything that was going on with Lionel Desmond; that he might have needed more

than one healthcare professional to sort of interact and help his complex portrait, I guess?

A. Well, I mean, certainly if somebody is taking medication there's going to be ... there's going to need to be a doctor or a psychiatrist, so that would be something that I would expect if medication was still involved.

But otherwise, I think that it's good for people to have these temporary times where they have these collaborative care models and they have an abundance of services, but that's not something I would recommend long term. You know, it's there to try to give people resources, to activate them, to show them, Hey, you know, if you do engage in physical activity, if you do go to therapy, if you socialize with other people, if you develop these skills you can feel better and then to go back into a place where it is one or two providers.

Q. I guess ...

A. Certainly if I had ... right now I have clients who are highly symptomatic, but I would not see an added value in having five professionals in an outpatient setting dealing with one person. That person would probably feel very overwhelmed.

(10:00)

Q. But in many ways, would it depend on the sort of state

or status of the client and what they ...

A. Oh yeah. In mental health everything is very much, you know, what are the individual needs and what's possible at this point, what might be a benefit, so it is really case-by-case basis.

Q. What is the ultimate goal, you know, from your perspective as a past clinical coordinator at Ste. Anne's, what is the ultimate goal for a client such as Lionel Desmond who attends the Ste. Anne's program? What is sort of the end goal? What do you try to achieve?

A. I think I've actually shifted since I've left. There were talks while I was there to have a little bit more of that trauma-focussed intervention. But certainly while I was there I think the idea was to really try to give people more resources, more skills, more coping, you know, healthy coping strategies so that they could return to their care teams and then feel more equipped to do kind of the trauma-focussed piece.

So there would be some kind of trauma processing in the background, but that wouldn't be the focus of the team. It really would be to get people to be activated to try to reduce some of those depressive symptoms. It really would be to teach people to have a little bit more strategies to deal with

difficult emotions; to interact with other people with hopefully less conflict; to set goals in everyday life and then reap the benefits from meeting these goals and having that kind of momentum build in their lives; to discover new interests potentially and then see the benefits of putting these interests ... actively engaging in these interests; of socializing; of having other people's perspectives that have different views.

So working on some of those problematic cognitions where they're perceiving things in a way that might be a little bit skewed. So I think the benefit, especially of that group treatment was really to allow people to have peers giving them a different perspective.

Q. So from where I stand, that seems like a lot.

A. As goals?

Q. Yes.

A. Well, it depends what kind of difficulties people came in with, right? But in general it really is to build a little more strategies to deal with whatever difficulties people are coming in with.

Q. So we're going to turn to Lionel Desmond and I think maybe this is a good context. So in Lionel Desmond's case what was the goal at Ste. Anne's? What was the end goal? What were

you trying to achieve and what was the treatment team? What were they trying to achieve with Lionel Desmond?

A. So when external treatment teams send us people they do identify what they think are goals, very general broad goals, that they'd like us to look at. In Mr. Desmond's case I believe that some of those goals are, for instance, medication readjustments, I believe also some diagnostic clarifications, and I think it was just generally kind of coping with situations.

In his work with me, I think a little bit more specifically there were quite a few difficulties identified with ... one of the big issues was managing emotions in general, so his reactions when he would have distressing emotions and his difficulties having healthy strategies to manage these emotions. So in our work together that was, I would say, you know, a main focus.

Q. So I'm going to turn to your ... the frequency of contact you would have had with Lionel Desmond.

Do you recall how often you would have and how frequent you would have had contact with him, whether on an individual session or in a group session?

A. So I believe that in the stabilization phase, I

usually saw people about on a weekly basis and then I think on the residential phase it usually decreases a little bit, and then I'll see people probably every two days, every three days, something like that.

Q. And I understand when Lionel ...

A. That was the average.

Q. And I understand when Lionel Desmond first entered the clinic he had a diagnosis already from the OSI clinic in New Brunswick. Do you recall what the diagnosis was?

A. I believe that's right. I don't think I was able to find it in my notes. I believe the diagnosis was PTSD, but then again that's from memory. That would have been kind of a summary sent us by the team.

Q. So and I know that Dr. Ouellette formulated his diagnosis and I understand that you did as well?

A. Well, if you read my assessment report, I definitely put it as a tentative picture of what was going on with him, because the truth was I felt that there was some information missing that I wanted to confirm or perhaps rule out in order to be able to make a little bit more of an informed assessment.

Q. And we're going to get into the details of why your diagnosis ...

A. Sure.

Q. ... was tentative, but generally could you tell us what that extra information was that you felt you needed before you could give a confident sort of diagnosis at the time?

A. So I did think that Mr. Desmond had some difficulties integrating information, you know, focussing during sessions, initiating actions and then stopping actions especially when he was upset about something, kind of repeating the same sentences. So to me it led to some questions about whether cognitively there might be some challenges that might be attributable to PTSD in the sense that one of the diagnostic criteria is difficulties with concentration. That would be a more intense expression than usually ... I usually observe in people, that's a possibility. But I did want to rule out if it was something as he'd reported brain or head injuries, I did want to rule out if that might be something that was happening.

Q. So moving forward, I sort of would like to start with the conclusion and then ...

A. Sure.

Q. ... go into individual sessions afterwards to fine tune the details. But if we could go to page 301 of Exhibit 254. So between pages 301 to pages 304, there's a report that's

called "Psychological Evaluation Report". Do you recognize that report?

A. Yes, that's my report.

Q. And that's a report that you had completed, I understand, on ... if we look to the last page, page 304, it looks to be completed on December 27th, 2016?

A. That's right.

Q. So that was the completion date of the report?

A. Yeah, that's when I put my final signature on there on that date, yeah.

Q. And so we know Lionel Desmond was discharged from Ste. Anne's in August of 2016 ...

A. Mm-hmm.

Q. Are you able to sort of say why the delay in finishing the report?

A. Yeah. It did take me longer than it usually does, I think because I usually like to have a little bit more of a firm assessment. So I did spend quite a bit of time reviewing my notes, reviewing the tests, re-reading my conclusions, and trying to come up with something that would both be accurate and that I wasn't extending myself past what I was able to say with some certainty, but also that would be of some use if somebody

used, say, this report ... if that neuropsychological assessment that I was recommending was conducted that might be of some use to write the report.

So I did want it to be that ideal blend of useful but also as accurate as humanly possible. So I do remember spending quite a bit of time mulling over that report and reworking it.

Q. So our understanding is that this report was never forwarded on to Veterans Affairs ...

A. Mm-hmm.

Q. ... or the OSI clinic in New Brunswick. Is that your recollection as well?

A. I usually was not involved in the piece where documentation was sent out. I don't think it was a matter of habit to automatically send it out.

Q. So I guess ... so to your knowledge you complete a report like this and it's post-discharge and it's post ... there was a conference call where the internal Ste. Anne's team discusses matters of future treatment with the external treatment team.

A. That's right.

Q. So you prepare this report but as a general rule do you know if it gets sent to anyone or is there anyone at Ste.

Anne's that was responsible for saying, We have your detailed report, it's great, we should forward this on to Veterans Affairs Canada?

(10:10)

A. So the usual practice, again from memory, is we would get a summary and not all the reports from a client's file from the external team and then we would send a summary out so ...

Q. Yes. And we do know that the discharge summary report was prepared and forwarded on in October. But so, typically as a rule, the detailed psychological report would not get sent to sort of Veterans Affairs?

A. I don't believe it was a matter of habit, no. I think that that would have to be specifically requested or ... So the expectation would be that we would transmit information that was key during that call and then in that summary report.

Q. Okay. So your understanding it's just the summary report is what gets sent?

A. That's right. That's my understanding.

Q. So I'm going to ask you why was it, I guess, from your perspective important to complete this psychological report as you did? What was the purpose behind creating such a detailed report?

A. I'm not sure what you mean by that question.

Q. I guess you took your time obviously to make sure you got it right ...

A. Yeah.

Q. ... and you provided some great detail and we'll go through it, and it's a detailed psychological report, evaluation report as it relates to Lionel Desmond. What is the purpose behind providing such a report as this?

A. So, accuracy, that was something that was requested, right. That we try to clarify what was going on with the member, and I think that performing this report allowed me to re-identify those difficulties in terms of emotional regulation which was communicated to the external team.

Had there been the possibility of having a more definite diagnosis, that would have been, I think, helpful for the external team. And I think just identifying that there might be some cognitive difficulties and that should be something that would be ruled out, that would have been, I think, useful and clarifying. I think, you know, the more you're able to hone in on what the difficulties are the more you're able to orient care. So that would be the purpose.

Q. And we do know that as part of the discharge summary

report, you had some recommendations and a short summary as part of that report ...

A. Yeah.

Q. ... that gets forwarded on. Could you see some value in your detailed report to maybe an external team?

You know, at some point, I mean, there's this concept of continuity of care where Lionel Desmond is going to leave Ste. Anne's and someone is probably going to treat him at some point. Do you see some value, in being a clinician yourself, in being able to access this detailed report?

A. Being able to access it certainly. So if ... you know, if I'm treating someone and I know there's something and I don't believe this summary is enough I would probably request the assessment. So, yeah, that might have been useful.

I also like to think that, you know, the extra effort we put to prepare this summary report was really so that people could, in a reasonable amount of time, take in that information and be able to action it.

I think that the ... you know, I made a report, the social worker made a report, the psychiatrist made a report, so it has been sometimes in my experience that if you bury people in paperwork that's not necessarily more helpful either. So I

think that's where the idea of offering the summary is to really get to the essential. But I like to believe that the reports I spend a lot of time writing could be useful.

For instance, maybe that's something that would have been requested in the course of a neuropsychological assessment. I don't think they're essential, but yeah, I think it could have been useful.

Q. I guess in terms of on your end of things if, at the OSI New Brunswick, if the treating psychologist there, Dr. Murgatroyd, had prepared a psychological evaluation report in as much as detail as you did, would you have liked to have sort of looked at that and reviewed it before you approached Lionel Desmond at Ste. Anne's?

A. Yes and no. For instance, in my current work when somebody has had multiple assessments, sometimes I do like to go in with a fresh view, not coloured by previous assessments because I feel like that does put preconceptions in place, and so it might steer me in a direction and have me forego a path of inquiry that I might naturally go down had I not had that in the back of my mind.

I will, however, usually go back afterwards and read it to see, Oh, okay, that's something I hadn't observed. So I think

there's some value in both. I think having that information is good but I also think that making sure that you approach things from a new perspective is good, especially when somebody has had multiple assessments and there are some confusion or some deliberation maybe as to what's going on.

Q. So I guess moving it from the hypothetical, I guess, to more something concrete, I guess if a report such as this was prepared ...

A. Yes.

Q. ... and it was forwarded on to you, is it fair to say you would have had a look at it to see what value that it would have brought you in furthering the treatment of Lionel Desmond?

A. Yes, if I had documentation in front of me from a client I do review documentation that I have before treating people, sure.

Q. Okay. So if we look at page 301, and we'll go through it in fairly great detail, what was the purpose of the referral? I understand there were six sort of major purposes of this referral. I wonder if you could take us through what they were.

A. So these different referral reasons, there was a specific document that was sent out to external teams and they would basically tick off boxes to what they thought the client

might benefit, so these are meant to be very general.

Q. Yes.

A. So medication readjustment would be more, of course, the psychiatrist's work where he would review ... they would review the medication that was in place, assess if there were any better options, anything that could be taken out or added in.

Symptom stabilization would be to try to identify what symptoms are bothering the member and try to again provide the member with strategies to manage, minimize, tolerate some of these symptoms. And then the psychiatric evaluation would be again reviewing what might be going on diagnostically.

Psychosocial rehabilitation would be to try to have somebody really develop social skills, capacity for networking, capacity to manage what might be going on in terms of kind of psychological difficulties again. Emotional regulation would be, again, the capacity to regulate, manage, tolerate distressing emotions. Life skills would be, you know, everyday skills that we need in life and how to make goals, structure, plan effectively. And then healthy routine development would just be kind of self-care, sleep hygiene, having a structured day, those kind of considerations.

Q. So all of those six were identified as reasons or things to explore with treating Lionel Desmond, is that correct?

A. That's correct.

Q. I just want to review who would be involved in each one. So you indicated that medication readjustment would be a psychiatrist?

A. And potentially the generalist doctor that would come in just to see if there were any kind of physical health concerns, that would be more their territory.

Q. Okay. What mental health ...

A. Which is ...

Q. I'm sorry.

A. I will say, however, everything was collaborative care in the sense that if a client were to report to me that they were having significant side effects and told me maybe they felt, I don't know, uncomfortable or shy, embarrassed sharing those details with Dr. Ouellette for instance, that might be something I would bring up in our team meeting.

So all of these are collaborative in the sense that if we were not actively working on them we were sensitive to those concerns.

Q. Okay. Moving to the next one, symptom stabilization.

What healthcare clinicians or professionals would have been involved in that process?

A. I would say all the healthcare professionals in a sense that, you know, any intervention that you have with, say, even our yoga teacher. Some of our clients found that doing yoga was extremely helpful for them to try to manage some of their symptoms. So, you know, was she targeting specifically symptoms? No. Was she giving them one more opportunity to discover something that might help them manage symptoms? Yes.

Q. Anyone else in symptom stabilization? Any other sort of professional that would help there?

A. So I think all of them that I have mentioned previously. So psychiatrist, psychologist, social worker, occupational therapist, nurses. I think that that's definitely one of the areas where everybody was pitching in actively.

(10:20)

Q. Okay. So in-depth psychiatrist evaluation, who would have been involved in that? Which mental health professional?

A. That would have been probably a little more psychiatrist and psychologist.

Q. Okay. Psychological rehabilitation, which professionals would have been ...

A. So for psychosocial rehabilitation that would have been a piece where the social worker would have been very much actively involved, as well as myself, occupational therapist probably as well.

Q. Emotional regulation and life skills, who would have been involved in that?

A. I'm tempted to say pretty much all the professionals in the sense that we're all trying to work to help people manage their emotions in sessions, right. I mean, by definition in therapy you don't usually talk about the things that are going well, so they can be distressing. So I think, you know, in any session we're actively trying to help people manage and regulate emotions.

Life skills, our occupational therapist was probably a little bit more hands-on involved in that. One of the groups was very much targeting setting goals, how to go about reaching those goals and kind of structuring your activities.

Q. And finally, healthy routine development, who would have been involved in that?

A. I think, in general, the program tried to show people that, you know, in a more structured environment this is how your day is broken down. Here are some of the benefits that

you're now experiencing because you have a set hour to wake up in the morning because, you know, you have physical activity and social interaction built into your day.

So I think the program is structured in a way to try to help people develop a little bit more of a healthy routine and that was a point that everybody did highlight when possible.

Q. So what I take from this is that when Lionel Desmond attended Ste. Anne's there were six identifiable areas that required work and intervention. And when I count them up you indicated a psychiatrist, a general doctor, a yoga teacher, a psychologist, a social worker, occupational therapist and a nurse. So at a minimum there appears to be seven different professionals involved in this circle of care involving Lionel Desmond, is that right?

A. Yes, and I think I'm forgetting a few people, like an art teacher, a physical trainer, an addictions counsellor, yeah. So quite a few people, yes.

Q. So we're up to ten and in order to sort of achieve those goals, do you believe that it was important for those ten people to be involved?

A. Well, Ste. Anne's is considered kind of an intensive program so it ... you know you go there to try to have this, you

know, this time where things are very structured, where, you know, your whole day is devoted to this, so it's time outside of your normal routine that you go to do these things. So while you're there in a residential setting you take the opportunity to pile on these services.

So do I think that some of these goals could be reached with fewer people? I mean, probably, but there wouldn't be that intensive kind of focus.

Q. Okay. And what I want to review very quickly is when Lionel Desmond is ultimately discharged on August 15th, in your view did he still need some monitoring and follow-up as it relates to medication adjustment?

A. I really don't feel comfortable speaking to that because medication is not within my field of competences.

Q. What about symptom stabilization?

A. Yeah, I think that managing symptoms was still something that he struggled with and that he probably needed some support with.

Q. In-depth psychiatric evaluation, were there still areas to explore?

A. So I think that we had, you know, pushed forward on clarifying some things but I think there were still some

clarifications to do, yeah.

Q. Psychological rehabilitation, were there still aspects that required work?

A. You know, the issue is when people come to Ste. Anne's often they do find that being in a group setting when they are with peers is of some benefit to them. Certainly Mr. Desmond had indicated that this was the case.

So that's always hypothetical because we make recommendations to the client saying, You said that you enjoyed this, this and this part of the stay, what are you going to do when you return home to try to have that social support that's going to, you know, also provide some help with some of the difficulties psychologically that you're experiencing?

So it's hard to tell how people are going to do when they return back home if they're going to put some of these things in place. Are they going to make the move to connect with some old colleagues? Are they going to join a club? Are they going to, you know, reconnect well with their families?

So that's a little bit more of an interrogation mark because we don't know what actions clients are going to take when they return in their community to try to make sure that they engage socially.

Q. So psychosocial rehabilitation is dependent, but I guess, is it fair to say with Lionel Desmond it's something that ought to have been monitored when he leaves?

A. Well, "monitored" is maybe a strong word.

Q. Yeah, not monitored but ...

A. Maybe if he requested support it would have been good for him to have that.

Q. Okay. When he left, did he still require work on emotional regulation and life skills?

A. Absolutely. So that was an area where he struggled a lot and I think that that was something that he still needed to work on, yeah.

Q. And when he left did he still require some work on healthy routine development?

A. That's a little bit of the same situation as the psychosocial rehabilitation in the sense that, you know, by definition we provide a little bit of that routine at Ste. Anne's and we do encourage people to maintain that routine when they get home which a lot of people seem to.

But, again, we do send people out with recommendations that they maintain that routine and the question is: Do they maintain that? Is it difficult? Do they need support in doing that? I

think my expectation would have been that he probably needed some supporting maintaining that routine.

Q. And I guess consistent with that I'm going to move in to your observations of Lionel Desmond when it came to his attitudes maybe towards treatment or how he was able to keep on top of things. The second paragraph of your report on page 301 under "Observations" you say: "Mr. Desmond fre-" ... as a summary, you say: "Mr. Desmond frequently arrives late or not at all to scheduled meetings, requiring professionals to find him and remind him of these meetings."

Was this a recurring theme that you ran into with Lionel Desmond?

A. Mm-hmm. So there were a few instances, yes, of him being late or absent.

Q. What do you think was going on there? What do you think was accounting for that?

A. Hard to say but he did have a strong tendency to avoid, understandably, you know, difficult materials. I think that there was probably some hesitation. A lot of these difficulties were also when he arrived on the unit and, you know, a lot of clients have reported to us how discombobulating it is to arrive on the unit with this, you know, whole schedule

as opposed to what they've been doing at home.

So in the first weeks it's not completely unheard of with people, for people to be a little confused with the schedule, so I think it was a mix of difficulties with kind of setting and respecting times and routine, and probably a healthy dose of avoidance as well. That's my best guess.

Q. And clinically, what is avoidance and why is that sort of a concern from a psychologist? Why is that a concern?

A. Mm-hmm.

Q. What is it and what ...

A. So as with the case with most of the things that we discuss in psychology avoidance is on a continuum. I think we all do a little bit of avoidance. This is why so many people complete their taxes last minute because we all have a tendency to try to push back or put back or not do things that cause us stress, distress, suffering, sadness.

And so deliberately or sometimes a little bit less consciously we will try to, you know, not necessarily go to the meeting with the psychologist where she's going to ask me questions about difficult things that happened in my past. Again, in milder forms in every day life, it doesn't cause that many difficulties.

In terms of psychology and perhaps even more in terms of post-traumatic stress disorder that's problematic because that is one of the maintenance factors both in post-traumatic stress disorder and in anxiety, because the only way to reduce distress associated with certain things is to be exposed to them often on a repeated basis.

(10:30)

Q. So was avoidance a recurring theme with Lionel Desmond from sort of the start of his involvement with you and weeks before or a week before he left the program?

A. It was a recurring difficulty that he had, both in terms of avoiding events or people which would kind of create that difficulty or even in terms of him experiencing difficult or distressing emotions. You know, he would do a lot of things to distract himself to avoid feeling that way.

Q. And I guess a lot of times we hear this, past behaviour is a prediction of future behaviour and I don't necessarily say I like that term, but with Lionel Desmond, was there some real sort of suggestion that if he's exhibiting avoidance of meeting with clinicians weeks before he leaves Ste. Anne's, is that a distinct possibility that when he gets back in his home community it may be much the same?

A. Yeah, potentially. That's conjecture for my part, but I definitely would say it's not ... you know, it wouldn't be unlikely.

Q. You wouldn't be surprised if that was the case when he left?

A. No. No, I wouldn't be surprised that anybody with mental health difficulties would use avoidance as a strategy.

Q. Okay. And you noted, you said the client ... and this is again globally; it's a summary of your sessions. On that second paragraph on page 301: "The client displays pressured as we all tangential speech patterns. He alternates rapidly between different emotional states during the interviews, laughing loudly one moment to displaying pronounced anger at the next."

So I guess my first question is about the tangential speech patterns. Tell us a little bit about that and the significance clinically.

A. That can mean a few things. So tangential speech pattern would be, as an example, I ask you where you grew up, either because you don't want to discuss it or because you get easily distracted you start to say well, I grew up in, you know, Nova Scotia. And did you know that, you know, the provincial

bird of Nova Scotia is and then you go into these tangents that never circle back to the point of the question. So you leave into a direction that had nothing to do with the original question and so it's hard to gather information on the original question.

Q. So this is something ... did you frequently see this with Lionel Desmond recurring throughout your sessions with him?

A. Mm-hmm. Yeah, that's why I made it kind of a general observation because that did tend to come up again and again.

Q. What do you think was accounting for that?

A. Again, that can be a few things. I think that my main hypotheses were either difficulties with concentration. So, you know, any time that we talk about something we have associations in our mind and we tend to try to remain focussed by saying, Oh right, I'm thinking about this, but the point is the question I was just asked. And sometimes when we veer off course it's because you have trouble sorting through relevant information.

Or sometimes it's a function of avoidance where let me bury you in this irrelevant information so you don't ask me about where I grew up because that was difficult for me, for instance.

Q. Did he frequently have to be sort of redirected back on task, back on topic?

A. That was something I did have to do frequently, yes.

Q. Did you get a sense that that was sort of ... I don't want to say delay or getting in the way, but was it creating an added layer of difficulty when you're trying to get to the treatment?

A. I think that it added difficulty in obtaining information in the sense that I would have to ask a question multiple times and, you know, re-focus Mr. Desmond in order to get a small piece of information, so that made it a more lengthy process.

I'm not sure I would say complicated treatment because if you were acting this way with me in treatment that means it's part of your difficulties. So it's not something for me to try to brush aside, it's something for me to try to help you manage.

Q. Okay. And when you said these rapidly ... he would rapidly cycle between different emotional states, laughing loudly one moment and then anger the next. Was it very stark, I guess, the emotions that he was running through at any given session?

A. Mm-hmm. So very intense differences yes, and it was usually related to the subject matter. So talking about the weather today perfectly fine, you know, cheerful, laughing,

everything was fine and then, you know, when I tried to direct the session toward something like a conflict or difficult events from his past or some important decisions coming up in the future that's often where, you know, strong anxiety or anger or sadness would come up.

Q. How frequently would you observe these sort of very contrasting cycles of emotion with him?

A. Again, it would depend on the subjects that we addressed in session.

Q. Would it take much to sort of ... at one point in the same paragraph you said: "He would actually show overt signs of anger. For example, exhibit signs of anger such as clenched jaw, raised voice, finger pointing, unblinking eye contact and bared teeth."

A. Mm-hmm.

Q. Would that ... would you make those sort of observations frequently with him?

A. Again, it would really be situation dependent. So if we did address a situation where he had a conflict with somebody or a past event that was related to anger, then those emotions would come up, yes.

Q. And what do you think was accounting for that? Why

the sudden observable signs of anger?

A. I think that difficulties regulating anger would account for that. So, you know, when we would talk about a conflict ideally when we discuss conflict and you go back to these conflict we've thought about that conflict and maybe tried to see the other person's point of view or told yourself okay, well, that really made me angry in the moment, it's going to have no impact long term, it's not so bad, and you kind of, you know, internally use self-talk or, you know, deep breathing or some kind of, you know, tactic to try to gain some perspective and then anger is kind of reduced a little bit, and I think Mr. Desmond struggled a lot with that.

Q. In terms of ... there's a number of settings, and we'll go through them, where he had conflict with a number of individuals.

A. Mm-hmm.

Q. How did he sort of handle conflict? What was his, sort of, reaction to conflict? How was he doing with that?

A. Again, when we talk about conflict, a lot of managing conflict is trying to see the person's perspective, trying to see how your actions might have contributed to the situation. A lot of that what I'm describing falls under a bigger umbrella

skill called mentalization, which I think was very difficult for Mr. Desmond.

So, for instance, there might be a fairly neutral interaction that he would interpret as being directed towards him, being people, you know, laughing at him or being against him or trying to take advantage of him. And so challenging that perspective and trying to say, Well, what else might account for those behaviours or what else might be going on in somebody else's head, that was something that was difficult for him.

Q. So in terms of ... how was he in terms of throughout the program with being able to ground himself in a conflict scenario?

So with his emotional regulation, how was he and then how was he when he left the program? Did he ever get any success in reaching that?

A. So I think some limited progress. We tried a few different interventions to try to get him to develop skills. Because when he came in his only skill was avoidance. So what he would say is, you know, If I am angry with somebody or if I feel that this person is against me the only thing that I can do to try to avoid ... to not get into conflict, to not lose control and scream and throw things and ... which is what he

wanted to make sure didn't happen, would be to avoid that person, which, you know, only works to a certain extent, especially, for instance, if you're having conflict with somebody that's living on the unit. Avoidance is not the greatest strategy because that's going to have limited applications.

So we tried to identify different things that could happen that would help him kind of regulate anger and, therefore, make interactions with that person despite past conflicts a little bit easier. Some successes but I would say limited.

(10:40)

Q. So is it fair to say that when he left Ste. Anne's many interventions were tried. Was there still quite a bit of volatility to his emotional regulation and his anger?

A. That would be fair to say, yes.

Q. Was there still some volatility to his distrust of other people? This perception that other people maybe had it in for him?

A. I am not sure we'd call it volatility, I think I would say that that was kind of a skewed perception that he definitely still had, yes.

Q. And would you say he had limited success in dealing

with that by the time he left?

A. Yes. I would also say that these are usually skills that take quite a long time to develop. Changing the way that we habitually see things takes a lot of practice, a lot of effort, a lot of repetition to develop new ways of seeing things as a default.

Q. Okay. If we turn ... we're still at page 301 and turning in to page 302 a little bit, I understand that you did quite a bit of psychometric testing as it relates to Lionel Desmond. In particular, I have flagged four tests that you might have administered, the first being an Outcome Questionnaire 45.2. What is that?

A. So the OQ-45 is a test that is used often when we provide services in the sense that it allows us to monitor in a snapshot of time how somebody is doing with regards to general symptoms to social role and to interpersonal functioning. So it's got three subscales.

Q. And you noted the results of that, you said: "Lionel Desmond was in the clinically significant range with a moderately high level of distress." What does that mean in a practical sense for the rest of us here?

A. So what that would mean is there's a ... when you

create some of these tools and then you test them on a wide range of people you try to put a certain number, where past that number is people who you would say need support, are in significant distress, might benefit from treatment or therapy or interventions, and then below that number would be less significant. So that's the kind of clinical cutoff that we're talking about.

So a lot of tests that are elaborated come with these kind of lines that you can draw and above this ... somewhat artificial of course, but above this is where you would offer support and treatment therapy or interventions and then below would be kind of recovered when ... maybe ... what would be more considered the average population because everybody is expected to have some difficulties so ...

And then there's ranges that say ... again just for comparison sake, you know, is this distress extreme or minor or moderate, just to qualify in that clinical range where somebody is.

Q. And as sort of a subset, I guess, of this testing you said: "He was in the clinically ..." or the results were: "He was in the clinically significant range for three things: symptom distress, interpersonal relationship, and social role."

I wonder if you could tell us what each one of those are, I guess starting with symptom distress. What was it that put him in the clinically significant range? What would that involve?

A. So the subscale for his symptoms of distress would cover a broad range of symptoms. It's meant to capture just generally psychologically what might be happening, so it would include symptoms of difficulties with mood, with anxiety, with sleep, those kind of difficulties.

Then interpersonal relationships would cover kind of satisfaction in interpersonal relationships, conflict in interpersonal relationships.

And then social role would be ... it was sometimes a little bit less relevant because a lot of our clients just were not actively working but it would cover people's satisfaction with how they were doing at school or in a work setting.

Q. Okay. So these were, is it fair to say, identifiable areas that were, as a result of testing, suggesting that Lionel Desmond had struggles in these particular areas?

A. That's right.

Q. That was a terrible question but you answered it properly. Well ...

So next is the Post-Traumatic Checklist 5, the PCL-5. What

is that and what does it test for?

A. So that's a scale that was specifically developed to monitor and to assess symptoms of post-traumatic stress disorder. So, again, I'm not sure how much detail you want me to go. So it does cover the symptoms which are in the four main categories to have a diagnosis of PTSD, and it allows people to rate how much these different difficulties bother them.

Q. And as a result of this test you noted he was in the clinically significant range for those four scales I guess, or those four areas: avoidance subscales, intrusion, negative cognitions of mood, and hyperarousal. I guess if you can explain to us what the significance of those are.

A. So on this specific scale there's a one general and even that ... I won't get into it, but there's one general score that we try to use to see if somebody is in that clinical range where okay, I think this might be significant. This is not a diagnostic tool. It doesn't say if you're above that line you have a diagnosis of PTSD, but it certainly informs some of the questions you're going to be asking.

For the different categories like intrusion and avoidance and negative altercations in cognition and mood, there's no clinical cutoff.

I highlighted that when Mr. Desmond identified which of these difficulties was more salient for him, he seemed to say that the avoidance items were some of the items that bothered him moderately and then quite a bit in the intrusion negative cognition and mood and hyperarousal scale. So I was just trying to highlight which of these he reported bothered him more.

Q. Okay. So I guess he was clinically significant on?

A. The whole test.

Q. The whole. Okay. What is the Millon Clinical Multiaxial Inventory III?

A. So the MCMI is a test that helps us determine which ... several things, but in general helps us determine which personality features might be maladaptive, might be causing some difficulties in people's functioning in everyday life. So it's this long form that you fill out and that helps us kind of narrow down some of those difficulties.

Q. And what was sort of the results of that testing?

A. So those results I integrated in the general assessment where I identified some of the personality facets that Mr. Desmond presented that were a little bit more problematic.

Q. So in terms of ... I'm wondering if you could put a

summary in terms that, I guess, non-psychologists could understand that as a result of those four tests that you administered ...

A. So sorry, it's three.

Q. Oh three, sorry. As a result of those ...

A. No worries.

Q. ... three tests that you had administered, if you could put it in terms that non-psychologists could understand, what were you seeing about Lionel Desmond's clinical portrait?

A. So any time that you use some of these tests, and that's why there's that little paragraph that says, you know, yes, you use the tests that help your interpretation but that is informed by clinical observations. So I want to be clear that that's, you know, the combination that helps me make ... to draw conclusions for clinical portraits.

I'm trying to figure out how to make this a very short summary. So I think that when I do assessments, I do try to break down things either by spheres or sometimes by diagnoses. I think that, you know, in this report I tried a little bit more by spheres, in the sense that I said, Okay, well, there's difficulties in the interpersonal relationships with his spouse and his family in general, in a sense that they are the people

he interacts with most and there's some conflict, some lack of trust those relationships, but that's also reflected in general in his interactions with people around him.

(10:50)

This skew in his way of seeing things where fairly neutral interactions are interpreted as reasons not to trust to people or reasons to think that people are against him or want to take advantage of him, that was that significant kind of distrust lens that he was wearing in his interpersonal relationships and, of course, that would lead to quite a bit of conflict, some isolation.

And then I think that in the cognitive sphere I highlighted some of the things that we've discussed which is, you know, difficulties focusing on what we were discussing. Difficulties integrating new information. Difficulties planning, seeing ahead, understanding how other people perceived his actions, how his actions and his words and even his non-verbal could be interpreted by other people. So some of those kind of concerns were what led me to suggest that a neuropsychological assessment might be beneficial.

I think I also tried to speak to just his general structure as a person and some of the things he was dealing with, so those

are some of the personality features that I highlighted, like some impulsivity, difficulties with mentalization which we've discussed a little bit more before as well.

Am I being a little bit too clinical? I'm trying to give accurate information but be too obscure.

Q. No, I think that gives us a general sense.

A. Okay.

Q. And the purpose of the questioning just going forward I will start breaking down the parts, I guess, in your answer. So I guess if we move to conceptualization, you noted on page 302: "The client initially identifies his marital relationship as the main source of distress."

A. Mm-hmm.

Q. So in terms of things that were causing him distress, was that at the top of the scale, his marital relationship?

A. You know, I think ... and potentially this will be more and more illustrated when we cover maybe individual sessions. But I think that Mr. Desmond was having a lot of distress and had a tendency to want to identify one thing that he could focus on today or during the session or during the week that if he could solve this one thing then he would feel better.

So that would mean that, you know, when he showed up at

first he would say: If I can just fix this relationship I want to ... you know, I want to live with my wife and my daughter again. I want this to go well. I want to be a husband, I want to be a father and then things will go well. And that was kind of his focus.

But then throughout his stay at Ste. Anne's that shifted on multiple occasions. At some point it was: I just need to find a new job and if I find a new job then, you know, that will solve all my other difficulties. Or I just need to sell my house and if I ... once I sell my house there will be so much less stress then I will feel better.

So I think that there was a shifting. A tendency to shift from external stressor to external stressor as the main source of distress, whereas in the report I reflect that I think it's more a question of a lot of difficulties managing emotions when faced with stressors.

Q. And did this continue, this theme continue throughout the entirety of his stay at Ste. Anne's?

A. Yes. So some days he would say, you know, It's my relationship, that's what's going on, I need to focus on this. And then two sessions later it would be, It's a job. I need help to find a job. If I find a job it'll be fine. So this

kind of very, very narrow focus on one thing.

Whereas I would try a drawback and say, you know, I think the issue is managing stress around finding a new job. It's extremely stressful to think about going back on the job market, I understand that, but if we help you manage some of these emotions we will facilitate whatever next stressor comes down the line.

Q. And I understand that it's ... you know, and it's probably impossible to separate his depression and his post-traumatic stress disorder mixed personality traits from general stressors, whether it's in a marital context, whether it's finding a job, selling a house, living with your wife and child, navigating those dynamics.

How prominent were each of those? Is it fair to say that his external life stressors were as prominent as his, I'm having flashbacks about being in the military? Were they as equally as prominent as military flashbacks of PTSD?

A. Just to clarify. You're asking me if you thought that his external stressors were as distressing to him as his kind of ... the trauma events?

Q. Yes, I guess so. Yes.

A. Okay. I don't think I can make a determination on

that. Certainly he seemed more focussed on external stressor, but again, that might just mean they were less intimidating to him to address in sessions than events from the past, which he often quite categorically refused to discuss. So that was very difficult for me to assess and that's a very subjective thing in any case, right. That can be fluctuating throughout the day, in the moment.

Q. I guess in terms of his ... the subject matter of his complaints sort of to you that he's struggling with. Were those external stressors, marital external stressors, as prominent as his complaints as it relates to PTSD and flashbacks?

A. They were brought up by him more often as sources of distress.

Q. Okay. And the fact that they were brought up by him more often than the classic PTSD and flashbacks, what is that telling you as his clinical psychologist?

A. I think that all these things are inter-related, right. You know, if you have a diagnosis of mental health that usually makes it a little harder for you to manage everyday stresses. And if you have everyday stresses, that makes it harder to manage symptoms of mental health, so I think it's all inter-related.

And I think that the fact that he was focussing on these external stressors, you know, I think he was having a hard time and I think that he wanted to find something he could fix that was maybe a bit more tangible.

Q. So if I was to say to you, the source of Lionel Desmond's struggles with his mental health and difficulty were attributable to his post-traumatic stress disorder, what would be your answer to that?

A. I'm sorry, could you repeat that?

Q. If I made a declaration to you and said the source of Lionel Desmond's struggles with his mental health were attributable to his post-traumatic stress disorder, that's what's causing Lionel Desmond's troubles, what is your response to that?

A. I think that would be a very big over-simplification. I think that if that had been the case, that's what my report would have reflected. I would have said, you know, I see nothing else but symptoms of post-traumatic stress disorder which are making it hard for the member to manage everyday stressors. That's what I would have written in the report.

I definitely don't think it was as clear cut as that; I think there were multiple factors in play.

Q. Okay. You noted in your report that he indicates having sleeping difficulties partly due to recurring nightmares. This is, sorry, on page 302. "Mr. Desmond indicates having sleeping difficulties partly due to recurring nightmares of finding his wife cheating on him and attacking her and her lover."

I guess how frequent were his nightmares, I guess, if we break it down in general? Nightmare for anything.

A. So I usually try to give frequency of nightmares, so the fact that it's not in there tells me that I probably tried to ask the question and couldn't get a very definite answer.

Q. And in terms of the prominence of his reported nightmares, how often did they take the form of I'm having a flashback of a military context versus I'm having a nightmare about my wife cheating and her infidelity and acting out aggressively on someone?

A. So if you actually look at the next line. So it says: "When questioned on symptoms related to trauma events, the client says he cannot think of the past and refuses to elaborate." That's what that would mean.

That would mean that I tried to tease out what ... how many symptoms he was having that were related to deployment

events, to trauma events, and he refused to answer.

Q. So you couldn't really get a fair gauge as to were these connected to traumas in the military.

(11:00)

A. Unfortunately not. And this is not completely unusual. Some people who have trauma events in the past are very, very reluctant to discuss them, but it does make for a difficult assessment.

Q. And I understand from what we've learned so far, homicidal risk and suicidal risk is very much a clinical judgement based on a number of factors. My question is sort of this is you were treating Lionel Desmond. He tells you, I have a dream that I find my wife cheating and I attack her, I attack her lover. He's told Dr. Ouellette that he finds her cheating. He kills her in the dream.

A. Mm-hmm.

Q. Did you ever get any sense or try to flush out whether these self-reported dreams were him telling you that these are actually day-to-day thoughts, intrusive thoughts, that he may be having?

A. Mm-hmm. He definitely represented them to me as dreams. I think what you're suggesting, is it possible that

people would present something as a dream as being a more palatable way of reporting kind of an intrusive thought. I think that whether it's a dream or an intrusive thought, the most important piece of that would be his reporting that this is something that he struggles with and he finds very difficult, right? That then changes it. That's the distinction between a fantasy, which is pleasurable and, you know, he actively kind of engages in as something that might be a good thing, and something that he finds distressing, that he wants to get rid of.

And so if it was ... and again, this is pure conjecture. If it was his way of saying that this was something happening during the day, the most important piece attached to that was him saying, you know, This is something that I don't want in my life anymore.

Q. Was he ever able to, in the period of time that you had treated him at Ste. Anne's, was he ever able to get rid of those intrusive nightmares that, in a daily context, he was focussed on and they were of concern to him? Was he ever able to get past those?

A. No. So he did not actively report those nightmares to me after having discussed them in that assessment. Certainly,

his frustrations in his marital relationship remained to a certain extent, but I didn't monitor dreams from session to session.

Q. Okay. You noted at page 302 as well, you said, under "Current Symptoms": "The client mentions that yelling in the context of conflicts seems to trigger intrusive images of his deployment in Afghanistan." What do you mean by that?

A. So he had reported to me that any time, kind of, voices are raised and there's arguments and yelling, it tends to make him think back about deployment events. That's what I meant by that.

Q. So I guess there was some sort of connection, is it fair to say, that between him being involved in a verbal disagreement with someone, he could flash back to trauma he experienced in the military?

A. I'm not sure if it was traumatic events or not. So it might be, you know, orders being yelled at him or something like that, but certainly to kind of a more military setting.

Q. I'm just trying to find a passage here. The last paragraph on page 302, again with the cognitive functioning, you say: "Mr. Desmond seems to have difficulties assimilating information, often seeming to misunderstand questions or

assigned exercises."

A. Mm-hmm.

Q. What was happening there?

A. Unfortunately, I can't recall specific examples that I could give you, but it would be generally indicating that when I would ask him a question, he would give me an answer which seemed unrelated. And I can't remember any specific examples for these assigned exercises.

Q. Okay. I'm going to bounce back to the first paragraph under "Current Symptoms", probably midway through. You mentioned that: "In response to activation of traumatic memories or to physiological arousal, the client would now choose to leave the situation and to isolate himself. In the past, Mr. Desmond would have become aggressive, both verbally and physically." Is that something he disclosed to you?

A. Yes. So specific timeline was first difficult to establish and be at this point is a little vague, but I believe it was several years before this assessment there had been a situation where I think he was at a family event and an adult man was speaking with a raised voice at a child and this made him very upset and I think he pushed against the wall, this person, and I think he said to me that was very distressing to

him. And so he said, In order to avoid anything like this ever happening again, now when I get angry, I just leave the situation and I go by myself that way I can make sure that I don't ... I'm not physically aggressive with people.

Q. Did he ever disclose to you any occasions where he got either verbally or physically aggressive towards his wife or daughter?

A. I think he discussed with me raised voices which I think would be ... you know, I would hesitate to qualify that as verbal abuse.

Q. Sure.

A. But no, he never discussed with me any kind of physical violence with his wife or his daughter.

Q. Okay. And again in that same paragraph, you talk about: "Finally, as for hypervigilance, Mr. Desmond displays interpersonal distrust with some interpretations of events which verge on persecutory delusions."

A. Mm-hmm.

Q. What do you mean by that?

A. So delusions would be this kind of lack of contact with reality. And this, I think, was more present in his relationship with his wife, when he was convinced that she was

cheating on him. And he would, at times, kind of bounce back and say, No, I have no proof of this. I really don't think it's happening, but there's this kind of thought in my mind that won't go away that it's happening.

So this kind of skew towards, I have no proof. It's very unlikely. Part of me really doesn't believe it but there's this attachment to this kind of abstract belief that's kind of very anchored. So this kind of skew that I was talking about where there would be kind of a very neutral event. Like, at some point, he said ... I think he saw two mental health professionals kind of laughing together and he interpreted that as, You're laughing at me and that's a very big jump. That's a little bit telling as well.

Q. Clinically, what are you making of that? How are you assessing this information and what is it you're to ... how are you going to approach this? You have Lionel Desmond who tells you recurringly that he has this sort of deep distrust about his wife and he has this deep distrust about how she's managing perhaps the finances and accepting of him. He then talks about her infidelity in dreams.

So my question is, there's a recurring theme around stressors to him in one form or another, and Shanna Desmond.

And it seems to be always prominent. How are you interpreting that as his clinical psychologist and what is your approach to that?

A. So first, I'm not sure I would say that that's the main stressor. I think that any kind of external stressor was difficult for him to manage. And certainly this distrust that we're talking about seemed to be prevalent in all relationships. It's just that Mr. Desmond didn't have a ton of relationships, and for most people, our marital or close family relationships are our most significant ones and, therefore, there are the ones that can cause quite a bit of distress in us.

So rather than focusing more on one relationship, I was taking more of a broad view saying, When you have thoughts that are distrustful towards other people, how do you then challenge these thoughts to try just to have a little bit more flexibility and go, Is there any other way to interpret this? Any other hypotheses? And building in this flexibility is one of the things that does tend to help people manage anger.

(11:10)

Q. Was he able to demonstrate some success in doing that?

A. Not by himself. So if I were with him kind of coaching him, modeling this type of behaviour, if we were using

an example that was outside of his own situation. So let's say, you know, Person A and Person B have this discussion. Person A perceives this. Person B gets angry. What do you think might also be going on? Then he was able to, you know, be a little bit more flexible there.

But again, you know, when we see these type of really deeply anchored distrust, this is often, you know, something that's very longstanding and will require practice and practice and practice to develop this reflex to challenge our own automatic interpretations.

Q. You noted at the bottom of page 302 that there was marked cognitive rigidity in his clinical portrait. What was that, what was the significance of it, and what's an example?

A. So at the beginning of our discussion today, you asked if I was qualified to offer cognitive behavioural therapy. So one of the hallmarks of cognitive behavioural therapy is something that's called "cognitive restructuring" which is what we're discussing, right? This is your interpretation of an event. How do we build flexibility into that? How do we challenge that? Is that realistic? Is that helpful?

So when I was talking about Mr. Desmond being able to follow me in this exercise, usually, having seen that a few

times, people develop the capacity to do it at least a little bit by themselves. And that was very difficult for him. So that's the cognitive rigidity that I'm talking about, you know. His fixed ideas about, this is the interpretation that's right, this is what's going on, and then a lot of trouble moving and trying to consider other possibilities.

Q. And in his time at Ste. Anne's, was he ever able to have some success in reducing his cognitive rigidity?

A. Not by himself. So practicing in session was something that he was sometimes able to do, but he would've required more practice.

Q. Looking at page 303 and this idea of suicidal or homicidal ideation, you said: "Mr. Desmond does not report any suicidal or homicidal ideation. (It's at the very top.) In response to the client stating that if people disrespect him, that they will see the beast aspect of him, Mr. Desmond states that he would never hurt anyone." Or anybody, sorry.

A. Mm-hmm.

Q. So can you put that sort of in context about people disrespecting him and they will see the beast aspect of him and then saying, I would never hurt anyone? What are some examples of this discussion?

A. So that's also something that I noted a lot. In my notes, in my report, Mr. Desmond would use a lot of very particular imagery. So sometimes he would also describe when he would get angry as a tornado. You know, Oh, the tornado is coming in, the wind is picking up. These type of things. So to me, you know, once he said, you know, They'll see the beast aspect of me, my questions, which I think are again a bit more detailed in more of my session notes, were, Well, what do you mean by that? And then we explored what that meant. And then, you know, he described to me his fear of yelling, of throwing things, of damaging his relationships because one of the reasons he wanted to work on this, of course, was he could see the damaging impact that this was having on his relationships where when he got angry.

So there was this kind of duality where he would say, you know, I can't tolerate people taking advantage of me or disrespecting me or being mean to me, trying to take advantage of me. All these different things. So I want to tell them how angry this makes me but having very little capacity to express anger in a healthy way. And so it was all or nothing. Either he would withdraw and isolate or he would yell and scream and then the point would be kind of lost.

So that, again, in a lot of my notes, are some of the discussions that we had. How do we healthily express anger when we're upset at somebody when we think they're taking advantage of us. So the ... he stated he would never hurt anybody. That's when me, I was reviewing, Okay, well, are you worried that you could ... when you lose control, are you worried that you would hit somebody? Are you worried that you would ... the same incident that you described at that social gathering would happen again? He said, Well, that's definitely not my intention. That's why I isolate. That's because I don't want to do that. I wouldn't hurt people around me. So that intentionality was definitely something that he wasn't mentioning at that point.

Q. And is it fair to say that his coping strategies of either avoidance altogether and then perhaps ruminating about it, and yelling, would not have been productive coping strategies?

A. Certainly not the most helpful. And so that's why we were trying to develop more helpful ones.

Q. Did he have any success, again by the time he'd finished at Ste. Anne's, in implementing those coping strategies?

A. Again, very limited. You know, he identified a few things that he could do. For instance, one of the things he said was that, you know, if he did focus on having good self-care, like working out, he would have, like, a lower kind of baseline to start with, be a little bit more calm and, therefore, be in a better state to address some stressors. And I think the other thing that he mentioned was deep breathing. That was something that was helpful in helping him kind of calm down a little bit, to try to practice actually saying out loud, you know, Why am I bothered by this? Can you explain why you did this? And that second part was a lot more challenging.

Q. I'm going to shift gears a little bit and ask you about under "Past History". And what I'm interested in is Lionel Desmond was a black man in a rural community in Nova Scotia. He comes from a very difficult socioeconomic background. How does that play, or how did it play, in his trauma portrait, I guess, and how could it play clinically in the treatment ...

A. So if you do look at that ... sorry. If you do look at that passage, I also say that it was really difficult to get kind of precise, detailed, accurate information. Again, Mr. Desmond did use a lot of imagery which was sometimes a little

bit informative, but often a bit obscure as well. So when I asked more specific questions to really try to get at the heart of matters, what I did glean was that, certainly, he'd felt rejected and put aside by his peers in school, again because of his skin colour and his socioeconomic status. So to me, that means that this could be some of the foundations of that interpersonal distrust that we're seeing today, right? If you are feeling rejected, if you are feeling other input aside, that definitely doesn't build a great foundation to think that people are well-meaning towards you.

Q. In terms of ... there's this concept of seeing people through a culturally-competent lens. So basically, you're seeing Lionel Desmond as someone from that cultural background.

A. Mm-hmm.

Q. And is there room there for a recognition of that in the treatment and, if so, do you have any idea what that could be?

A. Again, perhaps more than I gave it, although it was fairly short-term, so it's hard to see where we would've built in the time. I think for more long-term, we could've tried to build some of that cognitive flexibility by seeing, you know, what the emotional impact of those childhood events might've

been.

I think that I like to take a global approach where we see kind of all the things that contributed to having this skew in our perception as adults. And so that would've been kind of taken into consideration where we're trying to build that flexibility. It's saying, There are reasons why you see things this way, right? I mean you've been through difficult events that have made you take this more protective, distrustful approach. Is it causing problems now more than it's helping you?

Q. Your Honour, I was going to move to sort of rounding out her global report. It's going to get into mixed personality traits and it's sort of the guarded diagnosis.

THE COURT: I think then what we might do, Dr. Gagnon, as indicated, we might take a morning break. And I get the signal from Mr. Russell that this is an appropriate time to do that. So we might break for we'll try and keep it to about 15 minutes, maybe 20 minutes max, okay? We'll let everyone stretch their legs, so to speak.

All right, thank you. We'll adjourn for now then.

COURT RECESSED (11:20 HRS)

COURT RESUMED (11:39 HRS)

THE COURT: Mr. Russell?

MR. RUSSELL: Thank you, Your Honour. And so where we left off, I was going to turn to ... Dr. Gagnon, I was going to turn to page 303, which was "Clinical Conceptualization".

A. Yes.

Q. What is "clinical conceptualization", I guess?

A. So it's trying to bring back all the elements that were earlier in the assessment to kind of an explanation of the functioning decline.

Q. And, again, I'm wondering ... I'm going to read you a passage and I'm wondering if you can sort of break it down for us so that we can understand. Right under "Clinical Conceptualization", you say: "To account for the client's clinical presentation, we pause at a complex interaction between a traumatic portrait, experiential avoidance, and personality traits and we underline the potential input from cognitive dysfunctions."

It appears to me that there's a lot in that paragraph, so I'm wondering if you could break it down for us and what does it mean.

A. Sure. So that is kind of the introduction line where I try to give a really brief summary. So that first part,

"traumatic portrait", right below that, again I kind of break things down in a little bit more detail. So I do say that I have an approximation of what traumatic symptoms the member might have. But that would be the influence of trauma events and how they cause dysfunction in his daily life. So again if I refer to my assessment, I would say some symptoms of intrusion, some symptoms of irritability and hypervigilance, negative affect, a lot of anger, interpersonal distrust. So that would be the piece where I detail a little bit what those traumas symptoms might be.

I do then go to say experiential avoidance in the sense that I did think that the level and the ... the level but also the wide-ranging impact of the avoidance the member was presenting was a little bit more intense than I usually observe in people who have a diagnosis of post-traumatic stress disorder. So I thought it might be a more longstanding habit of coping with things.

If you haven't been using avoidance for at least most of your life then, reasonably, I would expect people to have at least a few other coping skills that they could rely on. And I didn't observe much of that. So by "experiential avoidance", what I mean is not only avoiding external things which cause me

distress but also finding ways of distracting myself and not feeling emotions when they are distressing or not thinking about things when they are distressing, which of course bars us from dealing effectively with things when they come up.

And then "personality traits", which again I've described a little bit lower. Again, the magnitude and the fact that some of these personality traits were present in a lot of spheres, that they came up again and again, the very few details that I had from his childhood had me believe that they might, to some extent, be some personality features that the member had developed across his lifetime.

And then the last piece of that is that potential input from cognitive dysfunctions. That's some of the concentration, assimilation of the new information, kind of future planning that we had previously discussed.

Q. And as we move along, I'm going to touch on those various aspects, but I thank you for the general overview in terms of what that meant and how you applied it. Then you later sort of ... you qualify things even further. In a line down, you say, "However, we consider ..." you say: "We can only provide an approximate picture of the client's traumatic profile due to the client's reticence to discuss past events. However,

we consider that this very reticence speaks to the prominence of avoidance in the client's clinical portrait." What's going on there?

A. So, again, not unusual that people are reticent to discuss trauma events. You're talking about literally some of the most terrible things that happen in people's lives. But, you know, his ... usually, as the therapeutic alliance is established, people do become a little bit more open. And there was very little movement with that. And, you know, sometimes there was a flat-out refusal. So I did think that his avoidance for discussing these past events spoke to his general tendency of avoidance.

Q. So do I take from that ... you know, you're frequently having contact with him, but it was a constant sort of struggle, I guess, to peel back the layers to get him to discuss what it is that's underlying his condition.

A. Mm-hmm. So something that he would frequently say was, I can't think about the past. I've got to think about the future.

Q. And how was this sort of making things a little more challenging, I guess, when you're trying to come up with implementing treatment? So, basically, if he's resistant to

talk about the symptoms or the causes, how is that influencing your ability to effectively implement a treatment?

A. I think a lot of providing effective care to people is respecting their wishes when they're telling you what they need. So if somebody tells me that they flat out refuse to tell me about the things that have happened, then I've got to trust that they know that it would be a very dysregulating experience for them. And so, to me, that just gives me clinical information that we're not there yet and that we need to keep working on emotional regulation skills, on tolerating distress, on tolerating difficult events.

And so, again, stop me if I get a little too technical. But when we think about kind of an overarching framework in terms of treating post-traumatic stress disorder, often there's this thought that we can break it down in three different categories, the first category being kind of a stabilization phase where you develop a lot of these skills so that you then have the internal and external resources to do the more trauma-focussed work. And some people never get there.

Q. Were you ever ... in Lionel Desmond's time at Ste. Anne's, were you ever able to get there to a satisfactory level and ...

A. No.

Q. Oh, sorry. Go ahead.

A. I would say not so much. We were still kind of working to develop those skills. And some people spend, you know, quite a bit of time. And some people will say, I don't want to do this reprocessing bit, which is people's choices and certainly I wouldn't want to strong arm anybody into doing that.

Q. So that reticence and continued avoidance, that was present throughout his entirety of his stay at Ste. Anne's?

A. With regards to discussing trauma events, yes. And, sorry, just to qualify, I would get tidbits. It wasn't a flat refusal to ever discuss anything, but the reticence in a general way, yes, that was present the whole way through.

Q. Okay. And you indicate that the profile ... if I could have one moment to find. If we turn to page 304, there's a line and then there's sort of the first paragraph. You describe the profile as sort of tentative.

A. Uh-huh.

Q. Why was it tentative?

A. Again, because I wanted a little bit more information about potential input for cognitive dysfunction. For instance, when I mention that he might be displaying some borderline

personality traits, one of the symptoms of borderline personality disorder one of the traits that might be present for somebody that does have that diagnosis, would be impulsivity. There's some overlap. If somebody has a brain injury, that might also be part of that portrait. So, therefore, you know, I saw some of these signs and I didn't want to misattribute what that may be coming from, hence the tentative ...

Q. And we understood from talking to Dr. Ouellette yesterday he said he didn't diagnose Lionel Desmond with personality disorder as opposed to personality traits. Would you share that view?

A. That's right. That's right because, again, when you do have some of those hesitations about where some of these characteristics might be coming from, having had difficulties going back to an early age when we are talking about personality ... a disorder, a diagnosis of personality disorder, you really want to make sure this has been present for quite some time, from a younger age, a really longstanding pattern that's present in, you know, most if not all spheres of life, and that could not be attributed to either substance use or a more kind of brain injury, physical causes, or things like that.

(11:50)

So you want to be careful when you give these diagnoses. And so when you do have some hesitations on some of these other places where ... it could be having somebody's input. That's a way of saying, I've observed these traits. I'm holding off on placing a diagnosis of personality disorder. So I would concur with that, yes.

Q. And, in fact, you say on that first paragraph at page 304: "Indeed, Mr. Desmond seems to display a profile in which borderline personality traits seems prominent." So I guess there's two aspects of that. What were the borderline personality traits that you observed that he had and what made them prominent?

A. So if you look at all the session notes that I've produced in the course of Mr. Desmond's stay at Ste. Anne's, you'll notice a strong focus on emotional regulation. So one of the determining characteristics of people who do suffer from borderline personality disorder is intense fluctuations in emotions and difficulties regulating those emotions, one of these emotions being, of course, anger and often kind of inappropriate displays of anger. That would be, you know, yelling, screaming, or hitting, all these different inappropriate expressions of a very healthy emotion. So since I

thought that was a big part of the treatment, focus and a big central aspect of the member's difficulty where he could really make gains if he developed more skills, that's why I thought it was a prominent part of his clinical profile.

Q. So we understood from Dr. Ouellette's evidence yesterday that ... and I'm just wondering if you share the view, that personality traits can exist independently of another ... from more of a diagnosis of PTSD and PTSD can perhaps sometimes aggravate those personality traits. Am I understanding that correctly?

A. Yeah. So any kind of psychological difficulties will often have interactions. So, for instance, one of the diagnostic features of borderline personality disorder would be fear of abandonment and kind of a lot of thoughts around, Are people going to leave me? Do people have negative kind of intentions around that? And so that could have that kind of connecting line with post-traumatic stress disorder where we do have kind of that interpersonal distrust or negative thoughts about other people.

Q. And did you see that fear of abandonment with Lionel Desmond?

A. Certainly a fear that his spouse would be ending the

relationship. And then as treatment concluded, I also had some of those feelings, right, that he perceived some interventions that we were doing as "us" taking somebody else's side over his.

Q. Could you get a sense of when these ... and I mean I'm ... I understand that you had only seen him when he attended Ste. Anne's and you had limited access to his past. Could you get a sense from him how long these traits might have existed with him or were they something new?

A. That's part of the reason why I put in his report that it was a tentative diagnosis because I would want to go back and check again and again; you know, when was the first time that you felt this, can you think of examples in your youth or as a young adult where this was bothering you. You know, he gave me some clues from maybe when he was younger and he felt that kind of rejection from his peers. So that could be some of the origins there. But, again, that's why I put a lot of those very careful wording that I worked very hard to put in there to say, I think this might be going on and it would explain kind of the breadth of the expression of some of these personality traits. But I didn't want to, you know, put that in absolute terms.

Q. How did you go about, as a clinical psychologist ...

how did you go about treating those personality traits?

A. How would I go about in a general client, you mean?

Q. I guess how did you go about it as it relates to Mr. Desmond, in particular.

A. So when we do talk about personality traits, the expectation does come that work will be more long term and will require, you know, more repetition, more kind of repetitive work to change some of these features which, again, we suspect may be more longstanding. If your expectations of abandonment or mistreatment or rejection from other people stem from, you know, experiences that were from childhood, then you've had a long time to develop these kind of expectations from people. And so, reasonably, this would be something that's done a lot more long term. But some of what I was discussing, the emotional regulation being the key piece, regulating first, then creating some of that space to challenge some of our preconceptions about other people's motivations behind their actions, that would be the first steps in that direction.

Q. You noted that Lionel Desmond had an underdeveloped sense of self. What is a "sense of self" and why is it important for mental health or mental wellness?

A. So certainly our sense of self helps us, you know,

feel like we're taking active decisions in our lives and what we want, what are our key values? It really helps us make decisions about where to go in the future. And so in my discussions with Mr. Desmond, one thing that struck me a lot is he would ... for his future plans, he would kind of use these labels but then struggle very much to define what that would look like.

He would say something like, I just want to be a happy family. And then I would say, Okay, what would that look like, you know? Not a cookie-cutter family, but for you, what would constitute a happy family? Right? I just want to be a husband, I just want to be a father. But then it was like he wanted to get to that label but had a little bit of trouble figuring out what that would look like.

And so he was in that transition phase of leaving an organization which does come with a set of values, with camaraderie, often with a sense of purpose. And so I think that he identified strongly with some of these things. And so I underlined this because I think it's important when you have this important transition. Where there is transitioning to not being a husband anymore, not being a CAF member anymore, not living in a certain country anymore, these big life changes,

it's important to have a well-established sense of self where you can say, My life circumstances can change but I am still the me in this next situation and I can make good decisions to have the kind of future that's going to make me happy and feel purposeful and engaged.

Q. So you talk about the importance of having that sense of self in a veteran context when you make that transition from the military back to civilian life. And you said that Lionel Desmond very much struggled with that, he struggled with even being able to define whether or not what it means to be, I guess, a good father and a husband. Who was going to be able to help him with that and how would they go about doing it?

A. Certainly, I wouldn't want to suggest that I provide my clients with a sense of self. But, certainly, having him reflect on what he wanted from the future, what some of his core values might be, what type of hobbies or volunteering or paid work or engagement with the community that might make him feel like he was being coherent with who he wanted to be.

Q. And again that question of when Lionel Desmond walked out the door to the Ste. Anne's Clinic, what sort of quality or level of sense of self did he have?

A. Very, I would say, tenuous. And a lot of that will

have to be ... when people do have these big life changes, you know, trial and error. If I do join this community, is this a good fit for me? Do I feel like I belong here? Is this what's going to make me feel like I'm included and part of something? So some trial and error by the client is necessary. And then often support to encourage people to keep actively thinking about these things.

Q. You indicated that Lionel Desmond, as well, had dependent personality traits. What are "dependent personality traits" and what were the ones that Lionel Desmond had?

A. So I think that one, I put even some more limited observations. This was based on some observations that I made of Mr. Desmond where he ... I'm struggling to think of the exact situation, but I believe it was his case manager had either taken a little bit of time or said that she wasn't able to help him do something. And I do remember thinking, This seems like a little bit outside of the purview of a case manager. And he was very, very upset that this wasn't being done for him. I believe it was by his case manager. And so we had a discussion around that and I think what emerged was really the sense that he felt very abandoned when people wouldn't do these things for him and I think underprepared or underqualified to make some of these

decisions or take some of these actions by himself.

(12:00)

So when we talk about some dependent personality traits ... so again, I'm not diagnosing him with a definite personality disorder, but some traits might be expectations that other people take on some kind of everyday life responsibilities for us and some very significant frustration when that doesn't happen.

Q. Do you get a sense of how that would play out when he left Ste. Anne's and went into the community? What are some potential pitfalls for him having such dependent personality traits when he enters the community?

A. Mm-hmm. Again, limited observations, I just want to highlight that, but certainly probably continued frustrations if he felt his needs weren't being met.

Q. And how would you go about working on those?

A. So careful titration of trying to encourage people to see their abilities, building up competencies, and really making sure that people maintain that sense of autonomy and agency in making their own decision. I think that when there is that consideration that there might be some dependency, you really want to be careful not to have somebody become overreliant on

services or overreliant on people making life decisions for you.

And so for instance, you know, when Mr. Desmond was talking about moving back home, we were careful to try to make sure that he knew what some of those challenges and obstacles might be as to access to care, as to potential conflict with his in-laws or his spouse, and to make sure that he considered all options. But in order to respect people's right to autonomy and agency, we would certainly never say to somebody, This is what you should do, this is the right decision because, again, the risk for somebody that does have potentially some dependent traits would be that they kind of relinquish that autonomy.

Q. What sort of insight did he appear to have when it came to weighing options that he's been told about and considering options, and how did that interact with his rigidity?

A. So difficulties weighing options. I think that towards the end of the stay, there was a little bit more flexibility in the sense that I think there had been some conflict either with his family or his spouse and we could think, okay, well that might be difficult. So I think that opened up a little space for him to think, you know, Where could I stay? What might be possibilities if and when I return back

home. But it was difficult because when he did have an idea in mind of, you know, If I get there, then maybe things will be better, there was a lot of attachment to that idea.

Q. I'm going to ask you a little bit about ... and in your words, you put in here, "Possibility of brain trauma." So it's fair to say that you spent considerable time with Lionel Desmond in those months that he was at the clinic?

A. Yes, that's fair to say.

Q. And the second paragraph on page 304, you do say: "Given the interactions of these different factors and because of the potential input of brain trauma, we hesitate to provide a definitive diagnosis. (You go on to say) ... led us to determine the necessity of clarifying Mr. Desmond's neuropsychological state before elaborating (on) an evaluation of the client's clinical profile." And you say: "The reports of several incidents involving head and neck injuries further supports this course of action."

So with that, what was it about your ... first, what was it about your observations of Lionel Desmond that you thought might be consistent with brain trauma?

A. So this would be ... when I say assimilating information, this would be, you know, I would suggest a course

of action. We would practice something in session and you would come back the next session. And there would be very little ... again, assimilation would be, I've taken it and I've thought about it. I now know kind of in my context how I might use that. Not necessarily perfect from one session to the other, but there was very little. Less than I'm usually expecting to see.

Planning future events. Again, it was difficult for him when he was planning something, you know, saying, What might go wrong? What might be some of my obstacles? If that does go wrong, what could I then do to try to address a situation? Do I have a plan B? You know, is this going to be a good fit for me. Have I kind of practiced in my head what that might look like? So that kind of future planning, a little bit difficult.

Interrupting ongoing speech and actions. So that was when he would discuss something that was a little bit more emotionally activating, he would often kind of repeat the same sentences over and over and over, or kind of tell me the story, the same story, two times in a row. And I would point this out to him because we did have an agreement that I would interrupt him and try to kind of refocus some discussions. And he would look like he felt compelled to complete his story nevertheless.

So that raised some questions.

And so those are some of the things that I observed that made me wonder is this within the trauma portrait or are we talking about some cognitive deficits more specifically?

Q. What about something as simple, and I'm sure I'll stumble across it this afternoon, but I remember, there was a passage somewhere in your report about him interchangeably using the wrong words.

A. Mm-hmm.

Q. So maybe if he was saying, I went for a ride in my ... and I'm guilty of saying this, I went for a ride in my guitar, instead of car. Were there examples where he struggled with language and getting passages mixed up or words and terms mixed up?

A. So words mixed up, so not car/guitar, that would be too far. But something like a rock bed for a rock. So you know, this is not the exact expression that he used, but it would be something along the lines of, instead of saying, She's my rock, he would say something like, She's my rock bed.

So I didn't note it as prominent in this section because it might just be a question of vocabulary or getting the expression wrong. It happened enough for me to note it somewhere else in

the report, to think, is this something a bit different? But not enough that I thought it was one of the key features.

Q. Okay. And so ultimately, your provisional diagnosis is what?

A. So provisional diagnostic impressions would be, (1) post-traumatic stress disorder, and (2) borderline personality trait.

Q. Okay. And you had come up with an intervention plan and we talked about a lot of things but what were the main three items on the intervention plan that was going to happen at Ste. Anne's?

A. So most of these, because I felt that some of the key struggles of Mr. Desmond were related to emotional regulation and, therefore, of problematic interactions of his environment - obviously, we're not interacting optimally if we are feeling very angry - my first priority was developing emotional regulation skills. So one, by modeling. So in session, I would model things that I might use if I was feeling upset. So, you know, I might do some deep breathing. I might, you know, take some time and reflect on why this is bothering me and so on and so forth. And then because he was having trouble assimilating some of these interventions, I used the device which is called a

coping card which I sometimes use when individuals who do struggle to remember to use these tactics, which would be just a small piece of paper that somebody could carry with them that would give them kind of instructions on, Okay, regulate, breathe deeply now, recognize signs that you are becoming kind of emotionally dysregulated, and then try to take some time to formulate your thoughts, right? I think that was ... he would say he would have difficulties with communication, so that links with number two which would be more effective communication skills through role playing. So when he would be angry in session, we would have a long discussion about what was going on, what was his perception. If he were to try to discuss this with somebody else, what could he say to express why this was upsetting to him and how he felt this was perhaps taking advantage of him? And then when he would go into rumination, I would think, okay, well, you're repeating the same information. You're not discovering new information by discussing this with somebody. And so we would practice that. And then number three would be maintaining satisfying activities even when distress is experienced.

(12:10)

So one of the things that I observed during my session is

when an external stressor would happen, Mr. Desmond would kind of drop everything, all his self-care strategies, to kind of address his problem, which would leave him often feeling tired, sad, unsatisfied, and stressed. So I would say, Even if you spend all day completely focussed on solving this - for instance, I need a new job issue - you're not going to find a job in one day. So, you know, if you want to focus on this external stressor, that's fine, but then maintain your focus. Eat your meals. Work out. Communicate with loved ones. And then allocate two, three hours of your time where you are going to do something productive like, I'm going to work on my *CV*. I'm going to see if I have different skills. Where might I be employed?

So that kind of balance of having a structured kind of daily routine and maintaining those satisfying activities even when external stressors intrude. But this is a little bit part and parcel of emotional regulation.

Q. Did he have any success with that while at Ste. Anne's?

A. Some. I think that he really saw the benefits of, especially physical activity. You know, he really could see how, you know, yoga was helpful for him. When he was having a

stressful day, he did tend to go and, you know, play guitar. Some of these things. So I think that, there, he had some success and I believe he did express to me the idea that he would try to maintain things in place.

Q. Do you think that he benefitted from sort of a prearranged structure where, you know, he has yoga class, he has cycling, he has art therapy. Did he benefit from that sort of daily structure?

A. Yes. I think that most people who struggle with mental health ... actually, I think most people benefit from having kind of a structure and a routine they can follow. I think, in Mr. Desmond's case, having somebody organize that structure for him seemed to facilitate things, at least in the immediate.

Q. So I get from that it might've been a bit of a challenge for him to put all those parts together and maintain them, but if somebody was there to assist him, it would've been helpful.

A. Again, being very careful not to try to overstep our bounds as mental health providers where we're not telling people what they should be doing with their day, but just encouraging them to, you know, remember, What did you do with your day?

Let's keep an eye on this and monitor it together and see, you know, did you have different activities during your day? Did you solely focus on this problem that's giving you a lot of stress?

Q. So when he left Ste. Anne's, and you talked about he did very much appear to benefit from the structure, would he have benefitted from someone to assist him in continuing that sort of structure while in the community? Is that something you envisioned as a positive?

A. Well, who are you thinking about?

Q. I guess just in general. You saw him benefit from a structured organization and somebody helping him organize that in Ste. Anne's. Would there be a benefit to having that in a community setting after he left?

A. To a certain extent. So for instance, if I'm following somebody in psychotherapy, that might be, you know, one of the things that we touch on, but I think that there are multiple things that you can do that's just ... I want to avoid overfocussing on mental health as well because that wouldn't be ... I wouldn't necessarily want to assign somebody to structure somebody's day, but certainly, I, you know, would suggest ... I think one of my recommendations was for him to, you know, join

some kind of club where he could enjoy activities with people but maybe, you know, separate but together, right? Like cycling, right? Reducing the risk of a conflict, but having some of that socialization, right?

Having an external demand on your time like somebody expecting you to show up to a prearranged meeting, that's kind of imposing a little bit of external structure on your everyday. Sharing with your spouse your intention of working out every morning increases the chance that you're actually going to follow through.

So there are many ways of trying to impose a little bit more structure on our daily lives, which are helpful, but not necessarily limited to mental health professionals.

Q. Page 305 and 306 appears to be a ... it's called "Closing Note".

A. That's right.

Q. And at page 306, it's dated December 27, 2016. So this report is prepared by you, is that correct?

A. That's right.

Q. And it was prepared December 27, 2016?

A. So the closing note doesn't mean I saw the client. The closing note is the last piece of information that I sign to

say that I'm now closing this file.

Q. So the last work, I guess, or last document you would've produced as it relates to Lionel Desmond would've been on December 27th?

A. That's right. That's right.

Q. Is there a particular reason why - he left Ste. Anne's August 15th - that you're still working on a closing note months later at December 27th?

A. So that would be the same reason that I explained for the psychodiagnostic assessment. That's the piece that I worked on extensively, and as I mentioned, I wanted to get the formulation right. And then when I finished that assessment report, that's when I could produce that closing note. So my closing note was dependent on the report.

Q. And in this closing note, you ... under "Observed Changes" which are in the middle of the page, what were some of the positive observed changes you noted in Lionel Desmond during his course at Ste. Anne's?

A. So again, when in session, he was showing some anger and we encouraged him to try to look at other options, to try to share with us why some of these things were upsetting to him, then we could really observe him regulating emotions which was a

positive thing to see. But as mentioned here, doing that by himself, without somebody to really encourage him to do that, still remained a challenge. And the coping card had limited effectiveness because I think that he began to see it ... when we would encourage him to use it, he began to see it almost in an accusatory way, you know? This is for you to manage, as opposed to, this situation is genuinely stressful, which the two are not mutually exclusive.

And then what else did I note? I think I mentioned that he was able to recognize that some of his interpersonal behaviours were being ... were damaging. That was something that he struggled with throughout treatment as well, seeing that having an angry, non-verbal behaviour could definitely be distressing to other people. That was something that he mentioned.

However, as I think I detailed a little bit more in my individual notes, towards the end of his stay at Ste. Anne's, I think, through a combination of factors, I think he began to lose that trust in the treatment team and use a bit more isolation. So, you know, very limited treatment gains.

Q. And that's what I wanted to ask you about because you noted that towards the end, you said, "He expresses growing doubts about the intentions of the treatment team which led to

increased distrust and isolation."

A. Mm-hmm.

Q. So it appears as though he's kind of turned against the treatment team, I guess, in many ways. Was that a concern to you and why?

A. Well, so this is one of the reasons or one of the factors that might support the presence of borderline personality traits. This is something called "splitting", which happens a lot with people who have issues with borderline personality traits. And it's really that flip of the switch between, I am getting along with somebody. I think you're great. Thank you for trying to help me, until something negative happens and there is not that nuanced view of people as being fallible and saying things that might be hurtful without having negative intentions sometimes. And so that complete switch to a very negative perception is really one of the typical observations that we tend to make with people who have borderline personality traits.

So it wasn't concerning to me in the sense that it wasn't completely unexplained and out of character with some of the other observations that I had made in the time that he was at Ste. Anne's. It was unfortunate in the sense that I felt that

it might make him disregard some of the things that he had learned while at Ste. Anne's. Was that the case? I can't be sure because he was more and more guarded.

Q. So there's a natural, as you indicated, concern that he might disregard some of the things that you tried to help him with, but obviously, it was clear, would you say, that Lionel Desmond's continuity of care was going to continue after he left Ste. Anne's?

A. So the process, the usual process, that happened is an external team sends us a referral to say, We are having difficulties in this, this, and this field. Could you provide this intervention? We receive the member, we provide intervention, we provide feedback and recommendation to the original treatment team. I have very limited information, but from my understanding, this was partly disrupted by the member's move. The expectation was that we would follow this normal process but I'm not sure if that's what happened.

(12:20)

Q. And I want to ask you a little bit about, is it fair to say, when Lionel Desmond left Ste. Anne's, he had this perception of distrust about mental health clinicians in the Ste. Anne's context?

A. I'm not sure if it was absolute, but certainly we noticed some signs that that was present, yes.

Q. Is there a strong chance that when he would encounter a further mental health professional at the next phase in the community or in the ER setting or in his general practitioner's office in his community, that this sense of distrust may continue?

A. Not necessarily. Again, my observations for borderline personality traits were tentative, so I always want to stress that. However, if that same pattern of kind of idealization and then devaluation were followed, what does tend to happen in people who have those personality traits is that the next kind of provider would then be kind of overvalued and seen as very helpful and there would be kind of a strong kind of connection initially, but then potentially again followed by this pattern of devaluation. This flipping back and forth again is one of the key characteristics of people who have borderline personality traits.

Q. Is it possible that the opposite could occur where rather than overvalue the ER psychiatrist, he could perceive them as another healthcare professional that he shouldn't trust?

A. If you're asking me if this is possible, I can hardly

say this is impossible. Sure, this could be something that could occur. And this, you know, this splitting, this, you know, idolization devaluing, is a tendency. It's not set in stone.

Q. Okay. At this point, Your Honour, I was going to turn to highlights of the various sessions with the doctor. I can begin or we can break now and in the afternoon, we can deal with the individual sessions.

THE COURT: Perhaps we could break now. Doctor, we would normally break at 12:30, which I appreciate is 11:30 your time. We generally break for an hour for lunch, so I think that that's what we'll do this afternoon.

We would like to be able to re-establish the connection with you if we could, and maybe we'll break until it'll be 12:30 your time, and maybe sometime about 12:20 or thereabouts, if you could be close to your computer, we'll try and re-establish the link.

A. That's perfectly fine. I don't mean to get into technical detail. If that's perfectly fine, I'll just mute my microphone and turn off my camera and that way, we won't lose the link at all.

Q. That would be just fine. Thank you very much.

A. In that case, I'll be back at 12:20, Your Honour.

Q. All right. Thank you very much, Doctor. So we'll adjourn till 1:20.

COURT RECESSED (12:23 HRS)

COURT RESUMED (13:29 HRS)

THE COURT: Thank you.

MR. RUSSELL: Thank you, Your Honour.

THE COURT: Mr. Russell?

A. I apologize, I'm not sure if anybody can hear me but I don't have audio.

THE COURT: We can hear you just fine.

A. Now it's fine.

THE COURT: All right. Thank you. Mr. Russell?

MR. RUSSELL: Good afternoon, Dr. Gagnon.

A. Good afternoon.

Q. So my plan, I guess, going forward this afternoon is to sort of hit some highlights of your various sessions with Lionel Desmond, so we'll be moving around a little bit in the record.

A. Okay.

Q. So page 275 of Exhibit 254. So I note that this was May 31st, 2016, and it's titled "Initial Assessment". In this

particular initial assessment, approximately four lines down you make a note. You said: "He also indicates being preoccupied with his conjugal and familial status. He details the difficulties in his marriage and the effect they have on his daughter."

So at the very outset of your first meeting with Lionel Desmond he's talking about the struggles he's having within his relationship?

A. That's right, yes.

Q. And do you recall what it was ... the effects it was having on his daughter? What he was referring to? What was affecting his daughter?

A. I think ... from memory, I think he was concerned that seeing arguments just wasn't contributing to having a good dynamic in the family, from memory.

Q. You also noted that: "He makes reference to Facebook messages that he had and texts that lead him to feel worse from his wife." Do you recall what that was about?

A. I don't recall what the content was, I do recall that that's one of the difficulties of communication that we identified. That there was a lot of room for interpretation with written communication and that he would tend to interpret

them in ways that made him feel like the relationship was in danger or that she was criticizing him. I have, again, some vague memories of the specific nature.

Q. Did you get a sense that those texting and the messages were happening while he was at the clinic in Ste. Anne's?

A. I don't recall.

Q. And I'm going to turn to you, you indicate as it relates to cannabis, again the middle of the page, you said: "He indicates taking cannabis makes him feel uncomfortable and that he feels pressure from the group providing this drug, marijuana, for trauma."

What did he feel uncomfortable about as it relates to cannabis?

A. So I, again, have some memories of this interaction. So from what I remember he had tried cannabis to see if it would alleviate some of his symptoms and he said it did not. And then he reported he had experienced some negative effects from cannabis use; I think I recall it was increased anxiety. And that he had reported that he had felt worse while using cannabis to the members of this group, Marijuana for Trauma, and again he reported to me that he had been told to be quiet about these

negative effects; that he shouldn't tell other people because it would give people a negative perception of cannabis.

Q. And he talked about feeling sort of pressure as a result of that?

A. Mm-hmm.

Q. And finally, what were your general observations of Lionel Desmond in terms of his affect, his outward signs, his speech during this first session?

A. So in my observations, as you can read, he did appear tired, which is not uncommon with people when they first arrive at the unit, it is a big change and there's a lot of adaptation to do to this new environment. So some tiredness, same tangential patterns of speech that I observed throughout my meetings with him, and then some mild agitation when he starts to go into deployment events, but if I'm not mistaken we quickly veered away from that. So those were my observations.

Q. So if we turn to page 277, this is your second session or scheduled session with Lionel Desmond a week later, June 7th. My understanding is Lionel Desmond does not show up for this appointment?

A. That's right.

Q. And was there an explanation or some sort of context

as to where he was and why he didn't appear?

A. So that was addressed the next session when he was late for the next session.

Q. So my understanding is he didn't attend the session. He actually left the unit without noting his departure?

A. Yes. So normally we would ask for people to let us know when they were leaving the unit. I believe mostly for the stabilization phase. So he had left the unit. I'm not even sure if I specified what he was up to. It might have been to something just as simple as taking a walk. There was nothing specifically worrying about this, just he wasn't following procedure.

Q. And at the next ... if we turn to page 278, and this is about a week later again, June 13, it's a 55-minute session. What do you note about his attendance at this session?

A. So the way we'd work at Ste. Anne's is there was a board with all the appointments. I believe I came to meet up with him at the board for his scheduled session and he wasn't there, so we spent some time trying to contact him. I think we asked other participants where he were and found out he was playing pool, so a nurse actually managed to track him down. So he arrived late, he apologized, and just stated that he was

confused.

But since this was the second in this type of pattern that I addressed it with him, and I asked him to consider if this might be attempts to not having discussions around subjects which were upsetting to him.

Q. So in looking back in the global context of all your appointments with Lionel Desmond would you say, you know, this is two out of three times now - one he missed, one they had to go get him to bring him there - was this sort of an example of the avoidance you were talking about?

A. Again, multiple potential explanations for this kind of pattern? What I would say is it was potentially a combination of avoidance and difficulties with organization.

Q. And I understand in this session it's brought up the context of sort of his obsessive cleaning of the house and the effect it might have been having on himself and his relationship. I wonder if you could tell us a little bit about that?

A. So when I did start to discuss the tendency that a lot of people have to distract ourselves from upsetting emotions or to want to avoid situations where we have to deal with difficult emotions, I asked him if this resonated with him at all. If he

could think of anything else he was doing to try to avoid emotions. And this is something that he himself identified that he would do and that he was aware that he was doing it to try to keep his mind busy.

Q. And you also note at this session, you say: "When discussing fictitious situations, the client consistently generates catastrophic thoughts."

What was happening here at this session and what were the catastrophic thoughts?

A. So just as a little bit of extra detail. When I say "catastrophic" that's a term that's used often in cognitive behavioural therapy, and I apologize, that's a difficult word for me to pronounce in English. Catastrophization is a tendency that people have when they think of an obstacle or a problem to go to the worst potential outcome or consequence of something that may initially be benign. So I can't recall the specific scenarios that we were discussing.

I note it down this way so that I would know that this is a potentially an emerging pattern in his way of thinking about situations. So it's a start with, say, my spouse has sent me an email ... and again, this is purely fictitious scenario. My wife sends me an email saying, you know, you left with this

piece of documentation that I needed to sell the house, and then he would immediately go to it's terrible, we'll never be able to sell this house, I'm going to be in trouble financially and so on and so forth to really, you know, terrible outcomes. So that's what I meant by that line.

Q. So was it sort of a frequent theme that he would, in face of a stressor, resort to the thoughts of the worst possible outcome?

A. Certainly if not the worst possible outcome then thinking that a benign or a small situation could get worse. That would be his kind of assumption. And the same thing goes with interaction with people. So as part of a larger pattern, his interactions with people if they were neutral or even slightly conflictual, he would assume that meant they were against him in a very general way.

(13:40)

Q. Was he ever able to sort of get that under control to some extent, that sort of worst-case scenario thinking?

A. I think the best that I could say that I observed was beginning to understand that this was a pattern, which is an important step in the process, but only some small steps in that direction.

Q. There's a line here as well in the middle of the page, it says: "The client states he would like to be able to better express his needs in his romantic relationship and to reduce the frequency of aggressive thoughts." Were they connected, his relationship and aggressive thoughts?

A. If I try to remember what this is related to I believe that it was related to his tendency to leave interactions when they got conflictual, because he was scared he would break things, throw things and yell and damage his relationship and, therefore, never really got to actually have a conversation about the things that were legitimately bothering him.

Q. And what was the reason why he never got to have those conversations as to what was actually bothering him?

A. Because he would leave the situation to avoid some of those aggressive behaviours that he described in the past.

Q. Did he say what those aggressive thoughts were? Did he give you an insight as to what it was?

A. He might have at the moment but since I didn't note it down I can't be sure today.

Q. Okay. If we turn to page 279, this is the fourth session, June 20th, and it's still titled "Initial Assessment". Is there a reason why it's still called ... you're at the fourth

session, is there a reason why it's still called "Initial Assessment"?

A. That would just be in the context of having trouble gathering information; still having a developing idea of what was troubling the client. So four sessions is not something I would consider unreasonable if it's hard to get a read on what's going on with the client, just to keep gathering information.

Q. So I understand from a clinical standpoint, with Lionel Desmond it's taking a few recurring sessions to get this even off the ground so you can begin to understand what his portrait is?

A. That would be accurate, yes.

Q. And do you need to get this information before you really get to the root of how to treat the problems?

A. Part of the work at Ste. Anne's is really focussed on stabilization so there's no reason that these two processes can't happen in parallel, both beginning to try to put in place some basic structure to routine, some self-care, all of these things are pretty much recommended for all our incoming participants. So parallel processes of beginning care and continued assessment are not unreasonable.

Q. So we're almost a month in to his time at Ste. Anne's

and you note that he feels trapped. "Mr. Desmond indicates he's aware of his racing thoughts and that he feels trapped in a cycle of thoughts when an external event preoccupies him."

What is going on there?

A. So this is what we had previously discussed when we were looking at the assessment that I conducted, this tendency when an external stressor would occur to focus all his time and attention and to have all these kind of fictitious scenarios when things go terribly wrong when these external stressors happen. So this is what he was describing to me at that time.

Q. During the session, Lionel Desmond discloses to you, he describes himself as "a loose cannon", that's his term. In what context was that provided?

A. I can't recall today.

Q. Does that sort of comment prompt you to explore sort of risk for violence or ...

A. Mm-hmm. So that's right, I think it was in a constellation of things. A few comments he had made about aggressive thoughts. His difficulties expressing his needs when anger is present. So this would be things that in a fairly standard manner would have me, you know, checking what the potential for violence is.

Q. And I understand that he then, upon prompting, said he had no violent intentions towards any particular individual at the time?

A. Mm-hmm. So intent would be one of the things that we check, which he did not report to me. But then also other factors where it's not necessarily planned and intended but through more impulsive risk could also be present and so that's the rest of the questions that I asked.

Q. And you talk about sort of you observed a history of impulsive actions where Lionel Desmond acts impulsively. What are some examples of that impulsive conduct?

A. So driving under the influence. I think there was some general spending. What else did he report to me for impulsivity? I think that one of the things that also spoke to me was I believe that when he entered the program he had not spoken to us about moving or selling his home but now it was a priority.

So these kind of rapidly shifting goals where, you know, he had decided this was now the right move and he had to act on it right away, so that kind of impulsive decision-taking I think that's one of the things that was contributing to my mentioning impulsivity.

Q. Did he continue to sort of show signs of impulsivity up to the moment he left Ste. Anne's?

A. If by "impulsivity" we mean having difficulties stopping himself when he was, you know, angry, so displaying frustration. So in groups he would make comments without necessarily taking the time to think is this relevant, is this going to be hurtful to somebody else, so that kind of moderate signs of impulsivity.

Q. What do you think was getting sort of in the way of him being able to sort of take a step back when faced with a frustrating scenario, take a step back and say, I'm going to gather myself, collect myself, I won't be so reactionary or impulsive?

A. Mm-hmm. Again, I think that's multiple factors really having an influence on this ability to take a step back. Always harping on the same subject, but definitely emotional regulation is one of these skills which allow us to engage our pre-frontal cortex to have that capacity to think about potential consequences, to think about what might be the optimal scenario, what actions I should take now to have the best outcome, and it's really difficult to do that when we're in this very highly emotionally activated state. So that could be one factor.

And then as I also mentioned, during the assessment I did want to check if there was a more, you know, physical potentially contribution to having some of those difficulties.

Q. You touched on this earlier, but you noted in your report that he expressed to you during this session that he felt abandoned by his Veterans Affairs case manager. Right at the bottom of the page under "Interventions".

A. Yes. So I can't remember what the incident was that prompted the member to feel abandoned by his case worker, that was the feelings that he reported to me. Oh, never mind ...

Q. You talk ... sorry.

A. ... it's written there. "Reasons for reported delays in call back." So he felt that his case manager had taken too long to get back to him.

Q. Did he ever express to you any other points in time where he felt frustrated with Veterans Affairs for whatever reason, do you recall?

A. He might but I can't think about specific examples today.

Q. And how did he seem to be reacting to this, you said ... I guess you noted as "feeling abandoned", you didn't note it as he was frustrated or disappointed that he didn't get a call-

back. Is it fair to say "feeling abandoned" seemed to be more of significance?

(13:50)

A. Certainly it seemed like a pretty strong reaction.

Q. So you make observations at this session in relation to his upcoming family visit and medication. What were sort of the observations you made regarding those two aspects?

A. So changing his medication was something that he thought was difficult. I think he had some misgivings about potential side effects. And then I think that just he was very anxious for his interactions with his family members to be positive, and I think that was the source of a little bit of his worry.

Q. And since I see it here, earlier on we talked about that sort of word substitution ...

A. Mm-hmm.

Q. ... and you were trying to think of the exact examples and I believe you said "rock" and "rock bed". What were the other examples that you noted?

A. So on there I noted "allocation" for "altercation", "focal" for "focus". So they're not big variations, so they could be accounted for just by mistakes in vocabulary. But just

in this session I noted three which seemed significant enough for me to wonder if this might be some difficulty ... more cognitive difficulty.

Q. If we could turn to page 281, this is the fifth session, June 28th. There's an indication here we're a month into the program and ... so I guess to begin, is this the first session after Lionel Desmond has a visit from Shanna and his daughter?

A. I believe so.

Q. And how did that visit go? Did he report back to you as to how he felt about that visit, how things were going?

A. So he did say that he was happy to see his family but I think also ... I'm not sure what interaction with his family caused this to be a concern for him, but I think that he felt that there might be some pressure for him to find a job, to kind of go back to being in the workforce and so that had become a real focus for him.

Q. Was this the first time that it came up that he's now talking about he is ... now feels pressure to find a new job?

A. I believe that was the first time it came up in our sessions, yes.

Q. So did it appear to you as though he was able to focus

on some of the positive aspects of the relationship with Shanna and Aaliyah who visited him that weekend or was he now turned to the, again, worst-case scenario thinking and talking about all the stressors of getting that relationship back together?

A. I think that there was a little bit of enjoyment but that that quickly transitioned to him being focussed on this external stressor and this perceived demand on his time that he deal with this new job that he wanted to find.

Q. In terms of his ... it's at this session that he talks a little bit about his early childhood experiences.

A. Mm-hmm.

Q. What sort of information were you provided? We don't have a whole lot of information about him as a child but what sort of information are you provided with at this session?

A. So, again, he described to me feeling rejected by his peers. I put a little bit more detail in his report as to the reasons why he might have felt rejected. He also said that he felt he had to become self-reliant fairly quickly because he was in a single-parent family and, therefore, presumably a lot of demands on that single parent.

And then he did also say that he hadn't learned as a child to necessarily express his needs and to be a little bit more

affirmative about the things he needed and wanted because he was a quiet child and, yeah, so as a childhood that's what he had reported to me.

Q. Under "Interventions" the last sort of three words you have it noted as "an emotionally-charged session."

A. Mm-hmm.

Q. What was it about this session that was "emotionally charged"?

A. As you can tell by the session, there was quite a bit covered in there and there was a lot of jumping around from pretty actually emotionally-charged subjects. So his family's visit and that pressure he felt to find a job, his childhood and some of the rejection he felt there, and then some descriptions of his experiences in the military and how he felt that he felt like an outsider from his unit. So a lot of strong emotions, experienced by the member during the session. So that's what I meant by "emotionally charged".

Q. How was he reacting to actually you sort of opening those wounds, I guess, and examining those sensitive areas?

A. So in my observations I also noted that there was a lot of use of imagery and so that was something that came around a lot and sometimes they were used to try to explain things and

it was difficult to get a little bit more precise.

You know, he might say something like. I'm a leaf in a stream and I've got to ride the waves when I was trying to get a sense of how he was feeling about things. So he definitely didn't shut those doors, because I would have respected that, but it certainly seemed to be difficult for him to talk about these things.

Q. And I note that this is the fifth session and you still have it noted as "Initial Assessment".

A. Mm-hmm, that's right.

Q. And is that for the same purpose of you're still at the stage of really trying to gather up ...

A. Mm-hmm. Mm-hmm.

Q. ... examine that iceberg which is Lionel Desmond, I guess?

A. Mm-hmm. Mm-hmm. Which, I think, was probably very helpful because I think it was this session where he gave me a little bit more information about his childhood, yeah.

Q. And was he such that it would require multiple sessions to really get to that information, you couldn't gather this after one or two meetings? Is that fair?

A. Mm-hmm. I think that yeah, for multiple reasons, one

of them being some of his reticence and just generally having a better therapeutic relationship would probably allow to open those doors a little bit easier and with potentially a little bit less distress for the member.

Q. If we could turn to page 282. This document is titled "Psychological Consultation". What was this? Who did you consult with and what was the purpose behind having this consultation which appears to be June 22nd?

A. So I believe that this meeting happened because Mr. Desmond had a meeting with Dr. Ouellette in which he was really reticent about changing medication and got very angry when the subject was brought up. And so we decided it might be best to all sit down together and try to, you know, figure out what the client wanted, what services we could offer that might match those needs, and also to check ... to keep again periodically checking in for any risks for violence.

Q. So I guess at this stage you said he becomes, I believe, angry at the idea of changing medications, and I know we heard from Dr. Ouellette. Did that seem disproportionate to what it was you were trying to accomplish?

Basically, you're suggesting him to maybe change medications or change doses and then his reaction to it is so

strong. Did that seem out of context to you?

A. I think a lot of people feel strongly about medication. I don't necessarily think his emotions were necessarily very much more intense than other people who feel strongly about medication and those are perfectly valid concerns.

I think this stemmed a lot from his difficulties in having a productive conversation about some of his concerns. I think that when he felt that his concerns ... he didn't agree with the medication change, I think that this is the only way he felt able to express those concerns, which was how to get really angry.

So I think the expression, the outward expression of emotion was more intense than we're used in seeing, but not necessarily his misgivings about taking medication.

Q. But his outward expressions seemed to be, is it fair to say, exaggerated?

A. I'm not sure. I feel like "exaggerate" maybe has some negative connotations, but quite strong.

Q. Okay. And I'm just going to read you a few lines, it's about the fifth line down on page 282: "When asked about his feelings of anger, Mr. Desmond recognizes that he has felt

out of control. He described incidents in which he was yelling at his wife and felt out of control." How does his wife come into the context of his anger and yelling when the discussion is really about medication at this consultation?

(14:00)

A. This discussion led to a more general discussion about anger and how sometimes he feels that he wants to express something but instead it comes out as shouting or yelling or just not really getting his point across, and so that lack of control on what he's actually ... the messages he's putting out there.

And so similar situations came up where he felt that he was not communicating effectively his actual concerns, but instead just having these outbursts of anger.

Q. Did he disclose to you that he felt out of control at times in the context of disagreements with his wife?

A. Yes, in a general sense he (audio/video freeze) ...

Q. Are you still there? I just want to double-check.

A. Oh ... yes. Can you hear me?

THE COURT: What happened, Doctor, was that the video feed froze for a minute and ...

A. Oh.

THE COURT: ... so whatever your answer was to Mr. Russell's last question, we didn't hear it.

A. Oh, okay. It seemed from my end everything was normal.

THE COURT: No.

A. So what I did answer was I think that in a general sense the member reported that when he was angry he would lose control of kind of the message or the goal he was trying to reach and instead would resort to kind of these outbursts of anger, which he very much recognized were unproductive.

MR. RUSSELL: Did he describe what those outbursts of anger ... what were they?

A. I think it was very generally described as yelling. Yeah.

Q. And did this prompt ... after that, you said: "When questioned about the possibility of attacking someone, the client denies any worry on the matter." So did you come right out and say do you plan on attacking someone or did he bring that up?

A. So I think that ... again, this is now dating back several years but if I am basing this on my usual way of proceeding, when somebody says something to me like "losing

control" that's a very general term, so then I'll usually yes, very openly say, Well, when you say losing control, what are your concerns? What will you fear you might do when you lose control? Is it yelling, is it pushing, is it punching, is it ... Are you worried that when you lose control you'll hurt somebody physically? And so that would be something standard that I would check so I'm assuming that this is what happened in this case as well.

Q. Did he express sort of concerns about potential side effects of medication?

A. I believe that that's something that he expressed, yes.

Q. I'm going to ask you ...

A. So yeah, that's what I wrote down. Yes.

Q. I'm going to ask you a question, I guess I'll put the examples to you first ...

A. Okay.

Q. ... and then I'll ask the question. At page 258, it'll take me a minute to go through all of the examples, but I think it's important. This is a report from Kama Hamilton where she's describing a point of conflict between Lionel Desmond and a nurse that was at Ste. Anne's.

A. Mm-hmm.

Q. And at the bottom, Lionel Desmond is describing the confrontation. And she writes:

> He expressed extreme anger in regards to the nurse having called security to be present when he was finally given his medication. He states that he is aware that the individual is afraid of him but states that 'I'm not putting that scare into him, he's putting it in himself'.

Then at the next page she says:

> Mr. Desmond alludes to the possibility that he will (and it's in quotes) 'snap if he has to deal with that nurse again' and then (and in quotes) 'He'll know what I'm like when I'm angry; he doesn't want to see me when I'm angry, really angry'.

And then he refers ... when he's asked he says he would break things. So that's one example.

I'm going to give you a second example before I ask the question, 279, and I believe this is your report. And this is back when he had referred to himself as a loose cannon in the

context of arguments with other individuals. He also said he had racing thoughts.

If we turn to page 302. I promise there is a question but I just want to lay the foundation for the question. That's where we refer to the passage where you said he had the recurring nightmares of his wife cheating on him and that he would attack her and her lover, he reveals that.

Page 303, at the very top, he refers to ... and we reviewed this earlier: "When people disrespect him they will see the beast aspect of him."

Those are five sort of examples of where Lionel Desmond expresses an outward suggestion of hostility or aggression to someone.

A. Mm-hmm.

Q. Would you say that he had sort of a history of implying that he's going to do harm to someone but then backing it up, backing off of that play? Was there a history of that with him?

A. I'm not sure if I understand the question. Could you rephrase that?

Q. I can rephrase it. Was there a pattern of Lionel Desmond alluding to the fact that I'm going to harm someone, but

then when he's questioned further he says, No, I'm not really going to do it? He backs away from the initial imply.

A. So just for my own understanding, I might be wrong, but I feel like maybe what you're suggesting is kind of making threats but then walking them back to avoid consequences. Would that be what you're alluding to?

Q. I wish I had asked the question that way.

A. Okay. Is this a possibility? Yes.

Was that what I suspected? If I thought ... if I had a little bit more certainty that that was what was happening, I probably would have written it down that way.

I think it was my understanding was more a combination of things, like having difficulty understanding what he was saying what kind of impact that would have on other people. I think that was one thing. And also his non-verbal. So we would find ourselves asking questions like can you understand why somebody might find that threatening.

Because there's a little bit of a disconnect ... the question that you were asking, it almost sounded like a lot of this was planned when, in fact, when we were asking a lot of these questions he was very activated and kind of saying things impulsively.

So to think that he would kind of stop in mid kind of angry tirade to them think, Oh, maybe somebody is going to think badly of this and then kind of walk back, I'm not sure if that was the first hypothesis that came to mind. Which is not to say, of course, that, you know, people aren't aware there are significant risks of outright saying that they're intent to harm other people, so I'm not sitting here and saying that's impossible, but that certainly wasn't my main hypothesis.

Q. And I recognize that, you know, those are from different sessions on different dates, there's a lot happening with Lionel Desmond. And I know it seems like a recurring ... a recurring theme, I guess, with mental health providers that we're seeing is that Lionel Desmond will make a comment, they'll ask him is he suicidal or if he's going to harm someone and his answer is no.

A. Mm-hmm.

Q. Do you ever sort of consider the whole as opposed to the immediate answer of no in the here and now when you're evaluating risk?

A. Yes. I will, however, note that I consider the whole in the sense that if you had three suicide attempts and today you're looking very distressed, you've got a bunch of stressors,

you're intoxicated and you tell me no, I'm going to have some doubts.

(14:10)

However, if you are having some suicidal thoughts today and you had some suicidal thoughts two weeks ago and two months ago, to me that's not necessarily an indication that increases the risk.

People have these thoughts of harming themselves and harming other people that come and go, and they're not necessarily cumulative actions which in my mind kind of increase that risk a little bit more cumulatively. If you say, No, I don't intend on harming somebody and you're constantly pushing people and there's this kind of an escalation in violence then I would start to doubt more and more and more. Does that make sense in explanation?

Q. That's fair.

A. Okay.

Q. Looking back at the whole picture of all of those different occurrences and the fact that he had interpersonal conflicts with nursing staff, other residents, other clients that were in group settings, do you openly accept Lionel Desmond when he tells you, No, I would never hurt anyone or harm anyone?

I know that's a tough question.

A. Mm-hmm. That's an especially tough question knowing what we know now ...

Q. Yes.

A. ... right. Having the information we know now, I'm tempted to say, Well, of course these were signs of potential violence. But, in actuality, I think that when I was in the situation, I saw it in a very positive light that he was absolutely furious at this mental health nurse and despite losing control in a verbal way managed to maintain control in a physical way.

And so to me having witnessed him, you know, very dysregulated and ... but definitely attempting his best to reign that in was kind of a promising sign that there was some control there.

Q. Is there ... I don't exactly know what this could be, but is there an advantage to ... because we appreciate that the mental health clinicians that are interacting with Lionel Desmond are very involved in trying to understand him, understand his conditions, put proper treatments in place.

Is there value in having sort of an independent eye who may be a clinician within a structure to go through these reports

and say, Look, I've documented five examples where he walks back his comments, to sort of understand whether there's an undercurrent of potential domestic violence risk?

Is there a value in that from a clinical perspective? I'm asking it because I don't know.

A. I'm not sure I know the answer to that question either. I'm not sure what the balance between that added work and the benefit might be.

You know, I'm thinking if I were handed somebody else's file to review it in some way and say are there concerns that I have missed, might I come up with points of interest or would I just end up engaging in, you know, asking for explanations and being given a lot more context because, you know, clinical notes are a snapshot in time. So I'm not sure I know the answer to that question.

THE COURT: Mr. Russell?

A. Is "maybe" an acceptable answer?

MR. RUSSELL: Okay. I believe Judge Zimmer may have ...

THE COURT: Dr. Gagnon ...

MR. RUSSELL: Or His Honour, sorry.

THE COURT: Sorry. A moment ago, when Mr. Russell was going through those various events and you made the comment

that, you know, thoughts can come and go but they're not necessarily cumulative ...

A. Mm-hmm.

THE COURT: ... and then you made a comment about we now know that what Cpl. Desmond did on January the 3rd.

A. Mm-hmm.

THE COURT: So when you look at all of these little bits and pieces that you saw then, would you look at them differently now knowing that that was the event ... that he came to that point in time when he, you know, basically killed his family and then committed suicide?

So do you look at these events now and you put them in a different light and say, Well, when we look at these I guess that maybe in isolation they didn't look a particular way, but knowing what happened we now look at them and can now fit them together into a puzzle that creates a picture that in hindsight - and I appreciate we are simply dealing with what this hindsight perspective is - that there was something more predictable in those circumstances than what was originally maybe appreciated?

A. I think when ... any new information is going to change my perspective, I think that's a given.

THE COURT: Yes.

A. You know, I think that when I learned of what had happened those were some of my first thoughts: Did I miss something? Should I go back, you know, knowing now what has happened does it change my view of these different incidents with anger?

So in a way ... in that way yes, but also in a way I don't think it changes the fact that inappropriate expression of anger and angry outbursts are a diagnostic criteria that does tend to pop up a lot for people who have post-traumatic stress disorder.

And when I currently treat people who have outbursts who will, I don't know, yell at someone, who will have, you know, yelling matches with their spouses, today this does not make me have overwhelming worries about safety. I still assess safety the same way.

So this has not changed my perspective in the sense that having yelling arguments to me is not a fantastic predictor of a lot more increased risks to safety. So there's a little bit of both, I think.

Do I think maybe there was something he wasn't telling us? Maybe.

THE COURT: Yeah. All right. Thank you, Doctor. Mr.

Russell?

A. Does it answer your question, Your Honour?

THE COURT: Oh, it does.

A. Okay.

THE COURT: I understand your point. Thank you.

MR. RUSSELL: So, Dr. Gagnon, we'll move to page 284.

A. Okay.

Q. There is a special sort of meeting that is held between you, Kama Hamilton, Ms. Marie-Eve Royer and ... I might pronounce her name improperly, Julie ...

A. Is it Beauchesne?

Q. ... Beauchesne? Yeah. What was the purpose of this meeting?

A. So I also want to point out because I do feel like we are focussing on these, as I completely understand why, but these type of meetings would happen, they were not unusual ...

Q. Oh, okay.

A. ... because we have multiple people from, you know, different environments coming together and having to live together on this unit 24/7, that does tend to cause some friction.

And so we would have these meetings with participants when

we noticed signs of frictions, either between participants or more frequently a little bit with the staff, to just address what was happening, what might be ways to resolve these types of difficulties.

And, in fact, I think that that was one of the clinical benefits of having this group environment where, you know, normal, habitual difficulties that these people are experiencing in the outside world get replicated in this group setting and we can practice in real time how to do some conflict resolution.

Q. So the meeting, what was the purpose behind it? What was the focus I guess of the meeting?

A. Trying to follow through some conflict resolution.

Q. So what was the source of the conflict that Lionel Desmond was experiencing while on the unit?

A. I can't even say that I remember. I seem to remember something maybe about dishes.

Q. It indicates: "The objectives of this meeting ...", it's the third line down. "The objectives of this meeting are to help the client maintain respectful interactions with the other participant and to develop tolerance for situations which generate anger." So there was some sort of encounter with another resident, am I getting that correctly?

A. Yeah, that would probably be a reasonable assumption.

Q. And your intention was sort of to bring this up with ... raise this with Mr. Desmond, I guess?

(14:20)

A. Mm-hmm.

Q. And what was the hope? You would raise it with him, what were you hoping to get out of that?

A. So to again try to make some of that difference between this is a situation which is causing some anger in you. It's not necessarily the other person deliberately trying to make you angry.

So these are situations where we have to make compromises where people might be, you know, creating frustrations in you quite unintentionally, and to develop this habit of giving the other people on the unit the benefit of the doubt to say we have some different opinions, they're not necessarily deliberately trying to make you angry, how do you tolerate some of these situations, and maintain a respectful interaction even though you might disagree on some things. So building some of those conflict resolution skills.

Q. And did Lionel Desmond seem to get or grasp that concept?

A. I have to say that not very much. I think there was very much an idea that I am angry because somebody else is making me angry.

Q. And did that sort of ... that foundation seem to stay in place throughout his stay at Ste. Anne's?

A. Again, some very limited beginning of flexibility there. So understanding, right. Take a step back if the situation exactly as it seems. Trying to understand other people's perspectives, but just some beginning in that direction.

Q. How did Lionel Desmond to you seem to take the news that you and the other clinicians were wishing to speak to him about this? How did he react to you approaching him?

A. I'm trying to remember and I can't really remember any specific reaction.

Q. This may prompt you, it's in the middle of that paragraph. You note: "Mr. Desmond is agitated through the first part of the session and he places responsibility of his frustration on the other participant." So you noted that he was agitated at the very discussion of the conflict?

A. Yeah, I'm not sure if this was ... I think maybe I misunderstood your question. I'm not sure if this was related

to us approaching him to have this discussion ...

Q. Okay.

A. ... or just him getting kind of worked up discussing this frustrating situation.

Q. But you can't re- ...

A. I suspect more the latter.

Q. If ... what was more the latter?

A. There was a pattern of the latter. There was a pattern of the latter in session where he would discuss something outside of session that was bothering him and him getting very much worked up just thinking again about how frustrating he had found this event.

Q. Okay. If we can move to page 285, this is a July 6th session. There's some discussion in this session about the transition to civilian life from military life and you indicated earlier that there were some struggles with Lionel Desmond getting that concept of his identity from the military to civilian life.

Did he talk about how that reflected in his home with his wife and daughter?

A. I can't remember any details. So in here I did write that, you know, he would just sometimes take home stress from

the day at home. I think that that's not so unusual. But apart from what I've written here, I can't recall any other examples he might have given me.

Q. Was there any discussion about anger directed at his family when he returned home from work?

A. I wrote "anger expressed towards his family", but no more detail than that.

Q. Okay. If we could turn to page 286. You discussed this concept of ... earlier on, of a coping card used as a tool for Lionel Desmond to sort of regulate his emotions in times of sort of stress. What is a coping card? What is that concept?

A. So it is a tool which I sometimes use with people who have trouble applying skills. So in between sessions they'll have trouble taking the skills which we've worked on in therapy, in those sessions, and then importing them into every day difficulties. So it would be a small piece of paper with simple reminders of actions that he could take to help him regulate emotions and have more productive interactions with other people.

In this case what I seem to describe is a very simple breathing exercise which we would have practiced in session and then with that slightly reduced kind of activation, taking a

step back and thinking about okay, what is making me angry right now; what is my need in this situation and building a sentence which would express that, as opposed to what he stated he struggled with which was just getting angry and yelling.

Q. Did he appear to be able to use these tools, breathing and the coping card, with success?

A. So towards the end - and I'm sure that this something that we might touch on as we hit those pages - he did say to me that he had really gotten used to the habit of kind of slow, diaphragmatic breathing as a means to calm down and so he had kind of discarded the coping card because he didn't really see any added value. I, of course, would have specified that I thought the second part of the exercise was also pretty useful. So partly but not wholly.

Q. If we turn to page 288, this is the seventh session, July 14th. I understand at this session ... I'll read to you, you note: "The client indicates he feels he has a low level of control on his internal state in a situation he finds upsetting and he states that this is the way things are because of his PTSD."

A. Mm-hmm.

Q. So again, was he still consistently reporting that

he's struggling with trying to control his emotions and regulate his emotions?

A. Yeah, that was very much an ongoing theme throughout his entire stay. And I think that in this line I tried to highlight how I was reflecting to him that through developing these skills he would learn to have more control over his emotions, his way of seeing things, and ultimately his reactions, and that his answer to me was to kind of give a reason why he didn't have that control.

So, to me, it really highlighted this continued difficulty with perceiving that he did have tools and strategies that would be effective in helping him manage how he felt.

Q. And the way it seems to be worded, it seems that he says to you this is the way things are because of his PTSD. So does he seem to be attributing this struggle with regulating emotions and his difficulties to I have PTSD, therefore, this is why I have these problems? Was that the level of his understanding into his conditions?

A. I think the last part of that line that this is the way things are because of his PTSD and then that following line: "He states that he finds the environment in the unit helpful because the other participants understand how he feels and ask

him permission before making comments." That was my way of illustrating that as I'm trying to get the client to move into a state of realizing that we do not have control over external events and, therefore, we have to make the effort to adapt and understand and process and regulate, he's kind of pushing back and giving me the complete opposite narrative, which is this environment is good, because people, you know, are very careful around me and that's helpful to me. And, you know, these are my reactions because of PTSD and that's why I can't control these things.

So I was trying to illustrate the fact that this was very much still a struggle for him to perceive that he had some control over things.

Q. And so did you see that there was a real value in Lionel Desmond being around people that he felt shared similar experiences and similar struggles? Other veterans.

A. Yes to that question. There is value with sharing experiences with peers and feeling understood.

No, in a way because I definitely don't want my clients to build the expectation that they'll feel better when others walk on eggshells around them. That's creating a very much unrealistic expectation and will probably increase anger when

you're confronted with people who rightly have no idea what you're going through and don't know what your triggers or your areas of sensitivities are.

(14:30)

And that's a huge part of what creates anger in a lot of people I treat, which is how dare you say something that's so insulting to me without realizing that a lot of people say things with no idea how it's going to have an influence on you. So to me, that was something, an aspect that was a bit less helpful because the more that you change an environment to accommodate these things, the less it reflects the natural environment, which is very stressful, that people are going to be ... have to evolve in.

Q. Do you think Lionel Desmond grasped the concept that, Other people might be walking on eggshells around me because of my reactionary ways of coping?

A. I think he saw it. I think he saw it and I think people did it also in a very benevolent way and I think he perceived that as very benevolent. I'm just not sure if, long-term, that was the most helpful thing.

Q. And did you see examples of where maybe staff or other clients at Ste. Anne's were sort of on eggshells around Lionel

Desmond?

A. Maybe "on eggshells" is pushing it a little bit, but I did notice ... so if you notice in my group sessions, he would often kind of go on tangents. And I think that for other clients, they might've been called to order a little bit more by the group, but I think that in Mr. Desmond's case, it was met, especially as sessions went on, in different ways, but often in people kind of giving him a little space but then continuing onto the subject.

So I think that people realized that he interacted in a certain way and they tried to give him space being that way, which I think was very kind of the people around him. I just wanted to make sure it didn't create that unrealistic expectation, especially when it comes to strangers.

Q. Okay. If we could turn to page 289, this is session eight and it appears to be July 19th. You indicated that you begin the session by asking the client if he has any challenging events over the past week and if he has been using his coping card. He talks about using the breathing exercises and you report that he found helpful. And then he goes on to ... you go on to note:

He identifies his relationship with his wife

> as his current concern. He explains that he has been telling her that he is committed to the relationship but that he has not received any information from her regarding his commitment. The client says he intends to confront his wife and that if she does not profess his (sic) love for him, it will mean that she has been taking advantage of him for financial reasons.

I'm going to ask you a little bit about that. Did it appear as though he was equating two things that really naturally don't line up? I'm going to confront my wife. If she doesn't profess her love for me, it confirms my belief that she's been taking advantage of me financially.

A. I think this goes back to the splitting concept that we were discussing where sometimes people see other people in very much a dichotomic way. Either you love me and you're going to be with me forever or you've never loved me and all along, this was a lie. So very much this inability to have a nuanced perspective of people where sometimes people fall out of love, sometimes people divorce. It doesn't mean the entire relationship was a lie.

So I think that, to him, he was saying, you know, I want to be a husband, I want to be with my family. I need this reassurance now, and if I don't then, you know, she was taking advantage of me and she never loved me and she was with me for money.

Q. This ... you referred to it a couple of times as the splitting concept.

A. Mm-hmm.

Q. Is that a clinical term or ...

A. Yeah.

Q. What is ...

A. It's a concept in psychology. So it's very much kind of splitting things in right or wrong, black or white. And so we often kind of look at people and they'll be all one way, and it's a way of kind of justifying the way that we feel about people. And so there's no nuanced grey areas, right? If we have a treatment team, when we do some splitting, there'll be the good guy and the bad guy, right? And there's no kind of understanding that people have. Things that we like about them, things that we don't like about them. And one mistake or one behaviour that we don't like doesn't mean that they're all negative.

Q. Did he seem very sincere at this concept that he was going to confront his wife about whether or not she will ...

A. Very much so.

Q. Yes?

A. Yes.

Q. That's something he really wanted assurances from his wife, Do you love me?

A. Yes.

Q. Now did it appear as though he had some concerns or beliefs that he couldn't have been ... I guess, did it appear as though he was prepared for maybe an answer that he didn't want?

A. Yes. Actually, this is one of the interactions that I remember a little bit better because this was one of the interactions that I found, to me, suggested that there was a lower risk of violence because when I asked him, What would you do if your wife told you that, no, she doesn't love you and she doesn't want to be with you anymore, he said to me that he would get ... I think he said, I would get revenge, or, I would make her pay, which obviously raised a little ... a few flags for me. So I told him, Okay, well, run me through a scenario of how you would make that happen. And he described this kind of elaborate fantasy of getting a lawyer and making sure that he would get

back every penny. And it was this kind of very big thing where, you know, she's not going to take advantage of me. I'm going to get that money back. It was a lot of emotional activation.

So, you know, when you're suggesting, do people sometimes kind of rehearse walking back threats and really in their mind they plan more violent actions, in this scenario, this seemed very authentic where he was thinking, this is what I'm going to do to punish my wife if she doesn't want to be with me anymore. You know, I'm going to take legal action. I'm going to make sure she knows that she can't, you know, take my money and get off scot-free.

So this is one of the sessions that I remember a little bit better. And so this kind of fantasy, to me, seemed very much like something that he was invested in, and as much as I would not wish that kind of, you know, painful process to anybody, that would've been, of course, perfectly within his rights and so a lot less worrying on the front of violence.

Q. So his thought process was he confronts her to find out if they're going to reconcile or whether she loves him, and if the answer is no, he's told you he's going to get revenge, make her pay. And then he describes ... he starts to clarify a bit more and says it's in a legal context?

A. Mm-hmm.

Q. I'm going to punish her financially? Is that what I'm getting?

A. I'm going to get every penny back. So his thought was that she'd used him for money to get her schooling, and now that she had her schooling, she didn't need him anymore. So his thought was, I'm going to get every penny back. And that was his kind of revenge scenario.

Q. But from what I understand, what came first is, I'm going to get revenge and I'm going to make her pay. Would that sort of have prompted you to say ... you indicated that that was a red flag, I believe you described. Would that have prompt-...

A. So just to be clear, something along those lines, but yeah. So some kind of frustration, right? She won't get away with taking advantage of me. So I wanted to clarify what that might entail, and that's when we got into this scenario of kind of getting his money back.

Q. So I guess, and so I'm clear, if he didn't get the answer he wanted, there was a sense that he was going to retaliate in some way that was going to inflict some sort of harm, whether it was financial or something. Is that the sense

I'm getting?

A. So the harm that he described to me was purely financial.

Q. Okay. Were there any other sort of circumstances where he expressed to you that he would take some sort of action against her that was going to almost be in a retaliation for the beliefs that he held?

A. The only retaliation that he ever described to me was that kind of financial restitution that he thought he wanted.

Q. Okay. And observations during this session. What sort of observations did you make of him when he's having that discussion with you about identifying his wife as the current concern?

(14:40)

A. So, you know, when he was describing this scenario, the possibility that his spouse ... or his belief or maybe his fear is the right word ... that his spouse has used him for financial reasons to get her schooling, and now that her schooling was done, she didn't need him anymore. So a lot of frustration, a lot of anger, you know, non-verbal expressions of anger, poor eye contacts, and swearing. So that's kind of the behaviour that he was exhibiting which highlighted his anger to

me.

Q. Did he use the analogy during this session that ... you say, "We explored cues which indicate he is feeling overwhelmed by intense affects. The client identifies tenseness in his body and uses the image of clouds rolling in." Did he use that to describe it?

A. Yeah. So this was ... you know, we try to use both kind of internal cues and imagery to say, These are the warning signs that you're getting very upset. How do you put in place things to help you regulate and help you maintain a state of a little bit more calmness?

So that was part of the imagery, right? There was the tornadoes, clouds were rolling in, tornadoes coming, there's a storm coming. Those were the kind of images, like, Okay, I'm getting really upset and I'm getting really drawn into this catastrophization and how do I manage now?

Q. If we could turn to page 290, this is a session from July 20th. There's a comment that Lionel Desmond makes to you in relation to the military, at the last of the first paragraph, the last two lines. "He indicates that being able to count on a close friend is an ability he would like to maintain in a civilian setting."

A. Mm-hmm.

Q. What sort of context did that come about?

A. I think that it was in the context of that earlier phrase where he was saying that, you know, his communication skills and his ... maybe the bluntness that's a little bit more prized in a military setting was having negative repercussions for him in a civilian setting, and that he wanted to be able to form friendships in the future. I believe that was what that referred to.

Q. We heard some evidence earlier on at the very first week about ... I don't want to say mentorship but where a military veteran can confide in someone that has a shared experience as them.

A. Mm-hmm.

Q. Someone they could confide in. Sort of a peer mentor or peer support. Do you see the value in that, having a sort of peer mentorship for someone such as Lionel Desmond? Someone that he can trust, someone he can confide in, someone he can call in the moment of perhaps having a difficult time?

A. Boy, I hate that all my answers are yes or no, but yes and no. I think that there is a lot of value in feeling like you have a sense of community, being surrounded by peers,

feeling like you have people that you can connect to. I think that what you might be referring to with that peer support is the ... I believe it's called the OSIS program.

Q. Okay, yes, I'm familiar with it

A. So a lot of benefits reported. I think one of the issues that I've sometimes come across is sometimes, it's a lot to manage for somebody acting as a peer, and so that can take a toll also. I'm looking at it from the point of view of taking care of the peers as well. So that's one of the things that I mentioned can be a little difficult. But in a general sense, maintaining contact with peers, you know, and having people around you that understand you and that can provide that support, that's generally a helpful thing.

Q. At this session, there's some indication that ... you note at the fourth line from the bottom: "Mr. Desmond seems to have limited insight into the potential distress that could be caused by his disparaging comment about Reserve members." What was that all about? What was happening there?

A. So I'm not sure if he was aware of this, but one of the participants in the group was ... I'm not sure if it's current or ex-Reservist. And Mr. Desmond kind of went on at length about kind of the downsides of working with Reservists.

And so I observed that there was a very real disconnect between him, you know, trying to get along with his peers and basically verbalizing that he'd found it helpful to have people that, you know, knew his experiences, and at the same time, saying something that could be very difficult to hear by another member of the group. And I did not, certainly did not, observe any moment of, Oops, I've just said that, you know, these people are hard to work with. How might somebody feel about that? And there were no repercussions from the group, again because I think that there was a lot of benevolence towards Mr. Desmond and understanding that he certainly wasn't looking to insult anybody on purpose.

Q. If we turn to page 291, this is July 21st, so we're now approximately two months into his time at Ste. Anne's and about three weeks before he leaves. From what I understand, this is a group intervention session about managing emotions.

A. That's right.

Q. What observations did you make of Lionel Desmond at this session?

A. So I think that this was one session where his tendency to speak impulsively and to interrupt other people was a little bit more present. So I would have to kind of refocus

him and make sure he left space for other people. Some of those things, I had noted.

Q. The fact that you note that he shows impulsivity, interrupting the clinician and other participants, is it becoming sort of concerning to you that he's nearing the sort of end of the program - he's two months in - and there's still a hard time getting traction in having effective treatment with Lionel Desmond?

A. What it is doing is indicating to me that this is going to be targets for future treatment and this is going to need continued attention.

Q. So something that even would postdate Ste. Anne's. It's something that's going to have to continue.

A. Mm-hmm.

Q. Do you think ... are you able to comment on what you think might be accounting for that continued sort of him interrupting the therapist, interrupting the other individuals in the group setting? What do you think is accounting for that?

A. I think that a lot of the things that I described in that report. And the reason I think I tried to frame something that made sense in that report is really those difficulties with impulsivity and mentalization, understanding, you know, if I

interrupt people, it might be upsetting to them. How do I manage my actions, not interrupt people?

So, again, we're on that cusp of could this be something more organic in the area of maybe kind of a head injury or is this something, a personality trait, more like impulsivity and difficulties understanding the impact of my actions on other people's actions?

Q. If we could move to page 292, this is a session from August 3rd titled "Thinking flexibly", I guess. So at this session - this is another group intervention session - what observations do you make of Lionel Desmond during this session?

A. Some of those same observations. So, you know, making jokes, talking and laughing loudly, making comments. So a little bit of that impulsivity again.

Q. Are you getting any sense of whether Lionel Desmond is getting anything out of these group sessions as you're nearing the tail end before he leaves?

A. I find that there's always benefit in repetition. There's a lot of echoes between the work individual sessions and the work in group sessions. I think there's also benefits in seeing other people do the work if, you know, you're too close to the source and you're having trouble doing it for yourself.

So some benefits in the larger scheme of things, yes. Some immediate gains, not very much.

Q. If we could move to 293, on the same date, August 3rd, there's a 60-minute sort of session and it appears to involve you and other staff at Ste. Anne's. Is this another scenario where you were actually confronting Lionel Desmond about his conduct at the group sessions?

A. Not in the group sessions. I believe this is an incident which occurred outside of group sessions. So this would've been an interaction, an altercation, between Mr. Desmond and a mental health nurse. And I believe this is the incident where he raised his voice, he acted kind of in a kind of posturally-aggressive way. So these was to kind of put the framework of saying that, you know, aggressive behaviour is not tolerated and that what we do expect of him is to practice those anger management skills which we've been developing.

(14:50)

Q. How did Lionel Desmond take sort of being confronted on you wanting to discuss that potential conflict and how to deal with the conflict? How did he react to that?

A. So I think that initially, there was very much the perspective that this was an "us versus him" kind of

intervention to kind of call him out and almost an imputed way to point out what he had done wrong. And I think that we tried to explain that, in kind of zooming out, this is just a good opportunity to practice these skills in real time. You know, these conflicts that you keep experiencing, this is a perfect place to practice how to deal with them more effectively.

So I think that had a little bit more traction, but I think there was very much a little bit of, You're taking his side versus mine.

Q. So when you say "had a little more traction" was he expressing a little bit of insight into how to appropriately deal with this?

A. I think that initially, what we could see was kind of interruptions. And then towards the end, the way I'm writing it, it sounds like he was able to listen when I said, you know, We need you to be able to express your frustrations. This is not to shut you down and not listen to some of the concerns you have. We just need to do it in a productive way. This is the perfect time to practice some of these, you know, more effective communication skills that we've been talking about. So I think he was more receptive to that towards the end.

Q. And I note in the middle of the page, you said: "He

shows signs of being agitated and states that he felt he had to walk away from the situation before becoming violent." Is that something he disclosed to you during this meeting, that he had to walk away from that situation with the nurse before he could ...

A. So that's what I wrote down that he would've reported to me, yes.

Q. I guess you can be violent to objects. Did he ...

A. Mm-hmm.

Q. Did he discuss what sort of violence was he going to participate in with the nurse if he didn't walk away?

A. I don't recall.

Q. Was it concerning that ... I guess it's a good thing in many ways that he said he recognized he had to walk away.

A. Mm-hmm.

Q. But is it fair to say it was concerning that he's reporting that, I had to walk away because I would've been violent?

A. I mean walking away instead of ... again, he did not report to me that he was going to punch the mental health nurse but, hypothetically, walking away instead of punching someone is very functional, especially for people who struggle with a lot

of anger. And I think what I said next was, That's good, but we want you to have other options. You know, if you have calmed down afterwards, why don't we then all sit down and have a discussion around why that was frustrating for you instead of just having this now, stuck in this place where you're both holding this situation, this altercation, in stasis and there's no good that's come of it.

So, you know, part of it was, Sure, I mean withdrawing from a situation if you feel that you're going to lose control violently in any form, shape, way, or form, is a good thing. We just want you to have other options at your disposal as well.

Q. Okay. 294. Two days later, on August 5th, I understand that yourself and Ms. Hamilton are trying to reach Shanna Desmond.

A. I believe that's right.

Q. What was the purpose of trying to reach out to Shanna Desmond two days later on August 5th?

A. I believe that the purpose of the call was Mr. Desmond stating that he wanted to discuss some of his needs in a more kind of proactive way, as we had been discussing throughout his stay at Ste. Anne's. Having a discussion around what might be put in place to improve the chances of this going well. And he

felt like in order for this to go as well as possible, he had asked us to sit with him and help him try to make that conversation as productive as possible.

Q. You indicate that you had some discussion, or turned your mind to, affect regulation in advance of this phone call?

A. Mm-hmm.

Q. What was that? What was the purpose behind affect regulation and Lionel Desmond before he called Shanna Desmond?

A. Well, I think actually it would've been in the context of the phone call. So, for instance, if a sensitive subject would've begun to be discussed and he could've become very activated and dysregulated and then started to either want to leave or to resort to kind of yelling, we could've helped him then kind of use the tactics that we'd identified together to be able to make that conversation productive.

Q. So did you sort of review this with him before he called his wife, that we're there to support you if things aren't going as well as you would like? What was ... or no.

A. Actually, that was from him. He said, I want to have this discussion. Can you help me make this discussion go well.

Q. Okay. So he reached out to you to sort of help him navigate the conversation with his wife.

A. I believe ... that's my understanding, that's my memory, and from what I'm reading, that makes sense here.

Q. Okay. But I understand, in terms of your involvement, you weren't able to speak to her on this date.

A. No.

Q. If we could turn to page 295. It's now August 5th, and from what I understand with this report, is it fair to say Lionel Desmond is still hung up on, or thinking about, or stressed about the conflict he had with the nurse?

A. That's right, yes.

Q. Was there a particular reason why it appeared as though he couldn't let that encounter go, that it was still so prominent?

A. I'm mostly speculating here, but continued interaction with this nurse, probably. You know, the fact that, you know, they would've had to continue to interact, and I'm not sure Mr. Desmond was able to kind of verbalize what was bothering him. And then I think, again, this idea of this flip to a negative side where having now "taken this nurse's side", we were kind of against him.

Q. So he felt as though, even though you were trying to engage in helping him navigate the conflict that he now then

perceived you as turned against him?

A. Mm-hmm. So I mean this was a conversation ... this was, I thought, a very productive session in the sense that when he came in, you know, non-verbally, he appeared very angry. And when I asked him if he was angry initially, he said that wasn't the case, but we were able to tease out and to discuss this a little bit more productively.

Q. And you had noted in your report, this is the second line. "He stated that he understands the subcontext in the previous group meeting regarding this situation. Note that we expect him to apologize and 'kiss this nurse's ass' and this will not happen." So is that sort of a reflection of his belief that you're taking that nurse's side and ...

A. Yeah, and that what we want from him is for him to admit that this was his fault and to apologize and kind of take full responsibility for this.

Q. And you note under "Interventions", you say, "A breach in the therapeutic alliance is identified and attended to."

A. Mm-hmm.

Q. What do you mean there? What's the breach in the ... I guess it's self-explanatory ...

A. So ...

Q. ... in many ways but ...

A. So anytime ... a breach in a therapeutic alliance would be, you know, when either party has done something which threatens the collaborative nature of their work together, right? So a client being angry at me because he thinks that I'm taking somebody's side over his would definitely be an obstacle of working together. So there's no way that, in those kind of situations, I just go through motions in a session. So I would directly address that and see what we can productively take from that. And again, this is, you know, great opportunities to address in real time, difficulties with expressions of anger.

(15:00)

Q. So we're now a week before he's leaving and you note in the first line of "Interventions", "We emphatically confront the client regarding his now completely negative perception of the RTCOSI and of the therapeutic relationship in contrast with past experiences." The RTCOSI is what?

A. Residential Treatment Centre for Operational Stress Injury, St. Anne's.

Q. And you phrase it as, "now completely negative perception".

A. So I'm describing that light switch shift from, You

guys are here to help me. Thank you so much. I really appreciate it, to, You're against me, you know, you don't want anything from me apart from kissing somebody's ass.

All those kind of, that really rapid switch from a positive perception to a now wholly negative perception. So again, illustrating this rapid shift in that really all or nothing thinking that we've discussed previously.

Q. Were you or anyone else on the treatment team, at this point, ever able to pull him back into sort of the understanding of, No, look, we're trying to help you. You should trust us? Were you ever able to get that?

A. Some limited openings. I know at the end of the session that he kind of makes his own opening to try to repair the relationship by complimenting my shoes, and that was kind of a little typical of his ways of interacting too. Kind of an attempt to say, Oh, you know, I have something good to say about you. So some of those little openings where he would kind of recognize some things and, you know, make a compliment and try to ... also try to repair that breach were present, but I think that that distrust was there and I perceived it, in part, being some difficulties with ending a relationship. He knew he was leaving soon and it's hard to leave a place where you feel that

you've, you know, made some gains, you've had some support from peers. So this also might've just been an attempt to say, It's okay if I'm leaving because this was a bad place anyways.

Q. So almost sort of the relationship is coming to an end and maybe his way of sort of dealing with it?

A. Yeah. If you're struggling with kind of separation and abandonment, that can be a strategy.

Q. So his strategy to deal with the ending of a relationship and abandonment is to become frustrated, angry, and say, I don't trust you? Is that natural?

A. I'm speculating at this point, but I did get the feeling that, you know, being in this place where the relationship was ending was difficult for him and that was one way he was dealing with it.

Q. This way he was dealing with it, was this a symptom or cause from PTSD?

A. I understood it a little bit more as some of these kind of personality traits that I was highlighting. That difficulty with kind of abandonment, separation, rejection, and then that switch between overvaluing and devaluing those kind of typical core symptoms of borderline personality disorder. So I understood that in that context, but there is that distrust of

people that can really be accentuated by trauma events. So they're not separated.

Q. So at this point, you indicate that Lionel Desmond knows that the relationship with the clinic is nearing an end point. Is that correct?

A. That's right. He's scheduled to leave at this point, I believe.

Q. I'm going to ask you about your observations of when he shows up to this meeting. You note under "Observations", "The client arrives with a new hairstyle, a Mohawk cut which he refers to as his warrior hairstyle. Mr. Desmond shows up to the session visibly angry but denies any concerns when the clinician inquires about his mood. Poor eye contact, frown, abrupt movements, tense posture."

So right out of the gate, does Lionel Desmond show up to this, one of these last meetings, angry and upset?

A. Mm-hmm. So that initial kind of description that I gave of him being very kind of physically, visibly upset about something, but then kind of denying that he was bothered about anything. Being able to address that a little bit more in that little bit of kind of calming down and a little bit more opening.

Q. What was he angry and upset for when he basically went into ... right into the meeting? Did you ever find out?

A. I believe this was the session ... that was the session where he brought his perception that we were on the nurse's side, so I believe that was the source of the anger.

Q. Okay. What, if anything ... people can wear different hairstyles, and I get it.

A. Mm-hmm.

Q. What did you make of the fact that he showed up with wearing a Mohawk hairstyle and then he refers to it and says it's his warrior hairstyle?

A. I perceived it as an expression of anger that was ... I think it was a clumsy way of trying to show that he was angry. Throughout his stay and throughout his description of other interactions, he consistently describes difficulties bringing up his concerns to people in productive ways.

I mean if you read the session, it's not at all unreasonable to come to session with me and sit down and say, Listen, I really didn't appreciate this last meeting that we had. I really felt that you were taking the nurse's side. I feel like he had his share of responsibility in this interaction and I felt kind of disrespected in that meeting.

That would've been a productive way to bring about his concerns but that was very difficult for him. And so I think that, in a way, he did want things to be addressed. There were so many visible outward signs of anger. He was making very little attempts to conceal them. So I think it was his way of saying, I have something on my mind. I'm bothered by something. I want to address it. I'm just not sure how. So, you know, making efforts in his own way.

Q. So the final session, page 297, that you have with him from August 10th, it's a psychotherapy session and you begin the session with what he's about to take away from his time at the residential clinic. And how does that session go overall?

A. I think fairly productive. I think I did note there was still some moments where I felt he was a bit more guarded. I did feel that we managed to move away from being completely a negative perception of his stay, which I felt was positive. I thought that he was able to identify some things during his stay that was helpful to him but, you know, I think that he was still very much struggling with this idea of, The only way that I can be safe and not be disappointed by people is to keep to myself and to assume the position that people are not worthy of trust.

Q. And did this concept of this deep-seated distrust in

others, was that prominent at this very last session?

A. I'm not sure if I would say "prominent". I think a good part of the session was dedicated to trying to consolidate gains that he'd made during the session and to really have him be able to verbalize what was useful to him, but a significant part of the session, I think, was also spent discussing that, which I think is a good way to highlight that this is still an area of concern and struggle that needs to continue to be worked on.

Q. Did he express to you how he felt about people speaking French while in his presence?

A. Mm-hmm. I think that, for him, it was a worry that when people were talking French, it was a way for them to talk about him without him understanding.

Q. Was he concerned with that?

A. I think there was some understanding him about his difficulties with trusting others and sometimes his tendency to assume that position that there is something nefarious going on against him. So he, himself, referred to it as being paranoid. And so really, that skew in assuming that people are talking about him or are ... you know, don't mean him well.

(15:10)

Q. So did he equate people speaking the French language with, They're talking about me?

A. I'm not sure if that would've been in any ... in every situation, but certainly he said that that had occurred. I'm not sure if that was every time.

Q. Okay. What was the comment about, he kind of told you about, The walls aren't soundproof around here or something like that?

A. Yeah. So he was referring to the fact that, you know, he would've heard something said about him. I mean, as a general rule, we have team meetings, but they're very far from the unit, so I ... it's ... I'm not going to say impossible, but it's extremely unlikely he would've heard anything from the team meeting. And in any case, there's nothing that we say during team meetings that we wouldn't want clients to hear. It's all about coordinating care.

So I think that to him - again, this is speculative on my part - I wonder if he would've heard somebody say something in French and assumed that it would've been something against him. Or maybe he really did hear people talking behind his back. Again, speculative.

Q. Did you seem to ... is there a sense that ... and Dr.

Ouellette talked about paranoid personality traits. Did they seem to be reflective in this session?

A. Again, it's so difficult when we talk about personality traits. That would assume that this is very longstanding and more than just worry about kind of the end of relationship. That might've been the case. Yeah, that might've been some other kind of personality traits that had to be considered.

Q. You noted at this last session that he tells you, "The client refers to his distruthful side as a lone wolf and he identifies thoughts pertaining to protecting himself and not trusting anyone."

A. My apologies. I think there's an "s" missing there. "Distrustful side". So he, again, was a big fan of using kind of imagery to describe his emotions and how he felt and his kind of philosophy about how he had to be in life. So his "lone wolf" was just this kind of latest imagery that he would use to say, you know, I'm better off by myself. I think that it's better if I protect myself by maintaining distance from other people.

Q. And I understand that when he was ... the plan when he was leaving and going to go to the airport, he wanted someone to

accompany him to the airport?

A. Mm-hmm.

Q. And why was that important to him, did he say?

A. I think he felt a little worried that either the taxi driver would be French and he would be unable to communicate, or I think that in the previous situation, he had been with a taxi driver that spoke ... I'm not sure even if the taxi driver spoke Arabic or looked Middle Eastern, and that this was kind of activating for him.

Q. I believe your passage read, "He explains that when he is in a taxi and the driver speaks a foreign language, and even moreso when this individual is of Middle Eastern origin, he begins to feel uncomfortable not knowing where he is being taken and what is being said."

A. Mm-hmm.

Q. Do you recall that?

A. Yes, in a general sense, but again, where he's being taken, I'm not sure if he's ... I'm not sure if you're wondering if he's thinking he's being kidnapped. I think here, he's in a foreign city in a taxi cab with a taxi driver that doesn't necessarily speak the same language, and if the taxi driver is of Middle Eastern origin, that might also wake some residual

anxieties with regards to his deployment.

So I think there's a kind of constellation of factors which made him anxious.

Q. So collectively, when you look at this last session, at this last session he accuses staff of talking behind his back. He says the walls are not soundproof. When people are speaking French around him, they're talking about him. He wants someone to go with him to the airport because someone from a different ... Middle Eastern origin. He doesn't know where he's going to be taken or what is being said. And then he characterizes the tendency as being paranoid.

A. Mm-hmm.

Q. Is this paranoid-type conduct thought process behaviour, collectively?

A. It's certainly very distrustful. Does it kind of cross the line into outright paranoia? I don't know. I mean it's hard to tell in these situations. Maybe he did really hear either a participant or a staff made a comment about him which he thought was very difficult and then extrapolated that this was happening a lot. It's hard to say.

Q. And do you have ...

A. So I mean definitely distrustful.

Q. And do you have any contact with Lionel Desmond after this date?

A. I would have to say ... I would have to check if I saw him in ... I believe I saw him in group sessions afterwards.

Q. Perhaps on the same date. Page 299?

A. Yeah, I think on the same day, mm-hmm.

Q. August 10th.

A. So nothing too remarkable. I mean I did write down that he shared relevant examples of how he would've dealt with a presented situation, which is very good participation. He offered encouragement to other participants. So, you know, there were instances where that distrust was very much present, but there were also signs that he was trying to maintain some of those relationships. And just the fact that he asked for somebody from the unit to go with him in the taxi shows that the link of trust was not completely destroyed. But definitely a lot of distrust, yes.

Q. So I guess where you left off - I'll end sort of with this - is, from your perspective, when Lionel Desmond left Ste. Anne's on August 15th, knowing his psychological portrait and the complexities of all the various diagnoses, is he someone that would've required little continuity of care follow-up, a

medium level, high level, or extremely high level, based on your experience of what you know about him?

A. I'm not sure what you mean. In terms of frequency? In terms of number of caretakers?

Q. I guess my question is, in terms of having supports, mental health supports, was he in need of none, a medium level, high level, or extremely high level? And what I mean by "supports", are from various entities: social work, occupational therapist, psychiatrist, psychology. Where did he fall on that continuum?

A. I can only assess how he was at Ste. Anne's. I think that determination would've been, had to have been, made when he returned back home because then his entire situation changes. If the relationship with his spouse is going well, if he's found a place in the community, if he's getting some support from his in-laws, if he's maintaining kind of physical activity activation in those pleasant activities, then the answer might be little to medium.

If all of these things have fallen through then it's ... people's mental health is not in stasis, right? And so everything in the environment is going to dictate what kind of support people need. So you do need to kind of assess, by these

different snapshots, what's necessary at that time. Some support, absolutely, but I think I would've liked to know how he was settled back home to know what kind of services he needed.

Q. When you identified at the early outset about goals and interventions you wanted to work on, how satisfactory ... Did those goals get achieved to some extent or was there still a lot of work to be done?

A. I think there still remained quite a bit of work to be done.

Q. Okay.

A. I wouldn't have recommended this be the end of treatment. That, I can say with certainty.

Q. Okay. I thank you, Dr. Gagnon. Thank you so much. I know I asked you maybe some difficult questions there and you've been testifying for a while so far today.

Your Honour, I've concluded my questions, so turn it back to the Court.

THE COURT: All right, thank you, Mr. Russell.

Dr. Gagnon, Counsel may have some additional questions for you, so I'll give you the opportunity ... we could either continue. If we do, we'll probably continue until the questions are put to you. We can also take a break if you'd like to have

a short break.

A. I'd appreciate a short break, Your Honour.

Q. All right, fine. That's great then. We'll break for maybe 15 minutes. Will that be sufficient, Dr. Gagnon?

A. More than sufficient, thank you.

Q. All right, thank you then. So we'll adjourn for 15 minutes, Counsel, thank you.

COURT RECESSED (15:20 HRS)

COURT RESUMED (15:34 HRS.)

THE COURT: Thank you. Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour.

THE COURT: Thank you. Ms. Miller? Dr. Gagnon, you can hear us all right, I take it?

A. Yes, I can hear you well.

THE COURT: All right. Thank you.

CROSS-EXAMINATION BY MS. MILLER

(15:34)

MS. MILLER: Good afternoon, Dr. Gagnon. My name is Tara Miller and I'm the lawyer rep- ...

DR. ISABELLE GAGNON, Cross-Examination by Ms. Miller

A. Good afternoon.

Q. Good afternoon. I'm representing the personal representative for Brenda Desmond, so that was Cpl. Desmond's mom, and also the personal representative for Aaliyah Desmond who was, of course, Cpl. Desmond's daughter.

I wanted to ask you some questions about the role of family of veterans and members who are being treated at Ste. Anne's and, in particular, the residential treatment program. We heard from Dr. Ouellette yesterday that there was a day during the residential treatment program where family could come, so I'd like you to comment on that, and also if there are other avenues of involvement and engagement for family during that process.

A. I'm afraid I really don't have many details. Usually when family does come to visit, if they choose to do so for that day visit it really does serve the purpose of maintaining connection with family, you know, trying to foster that relationship, trying to see if there can be new, you know, forms of interaction with some progress that's hopefully been made in treatment, and also just getting some information about what your spouse might be going through. I'm not usually overly involved in that.

I believe that you're speaking with Mrs. Hamilton tomorrow?

Q. Correct.

A. And from memory, I think that she's more involved in the relationships with the family members.

Q. Okay. So that would not have been something that would have fallen under your umbrella of responsibility necessarily?

A. I was aware of it, it was integrated into the program, but I was certainly not organizing or orchestrating anything.

Q. Okay. From your resume, as I understand it, you started as the clinical care coordinator if I've got that correct, at ...

A. I think it's clinical coordinator.

Q. Clinical coordinator, thank you. You started at Ste. Anne's in April of 2016 and you ended in December of 2016?

A. I think I started going earlier to get some information. I believe so.

Q. Okay.

A. But that's accurate otherwise.

Q. How many patients/clients would you have seen, Dr. Gagnon, during that window of time in 2016? Are you able to say?

A. I tried to do the math earlier and I believe it would

have been somewhere between ... somewhere around 15 probably.

Q. Fifteen? One-five.

A. Teen. Yeah, one-five.

Q. Okay. And would that have ...

A. 15 to 20, I think.

Q. 15 to 20, okay. And would that have included patients in the stabilization unit as well as the ones that would then progress to the residential treatment program?

A. So the way that the unit is structured is stabilization and residential are living together, they're not separate. It's a program that's kind of meant to be continual. So the patients that I would have seen in the stabilization part of the program would have been progressed, in large part, to the residential program.

Q. Okay. And when you were there were there any people who didn't progress?

Dr. Ouellette yesterday told us that one of the ... one of his goals as a psychiatrist is to, you know, stabilize and then assess appropriateness for integration into the residential treatment program. Do you recall if there were folks that did not progress because they weren't appropriate?

A. I don't believe so. I believe some people did not

conclude - did not finish the program because the fit just wasn't right, but I don't remember somebody leaving after stabilization. I know this might be hard to believe, but some details have gotten very vague after four years unfortunately.

Q. It's not hard to believe at all, Dr. Gagnon.

I wanted to ask you about your ... so from your evidence, the goal for your perspective I think you said this morning with my friend, Mr. Russell, was to return members to treatment teams with more skills and strategies to address their issues moving forward. Is that ... did I capture that ...

A. That's right.

Q. ... that correctly? Yes.

You talked about too there is sort of three gold standard treatments for PTSD and those would be EMDR?

A. That's right.

Q. Yeah. And then cognitive behavioural therapy of which prolonged exposure is a subset. Is that accurate?

A. That's right.

Q. And is the third one cognitive processing therapy or thought processing therapy?

A. Cognitive processing therapy. That's right.

Q. Okay. And through your time with Cpl. Desmond in the

residential treatment program, were you able to engage in any of those three treatments?

(15:40)

A. So, the ... you know, when I say "gold standard" these are treatments that are manualized, so they're often kind of the best study. You know, CBT in general is considered one of those, a bit of a golden approach. So I think again that may have shifted since I've left, but the goal when people were at Ste. Anne's was not necessarily to do that processing phase.

Q. Yeah.

A. I'm sorry, I hope I'm not throwing too much technical detail. But often when we treat PTSD there's this overarching kind of treatment progress, which is that stabilization phase where we enhance people's skills, you know, we deal with any kind of pressing stressors, you know, sleep hygiene, self-care, behavioural activation, all these things.

And then the second phase would be that trauma processing phase, where we use those treatments like CPT, prolonged exposure and EMDR. And then the third phase would usually be reintegration where treatment is slowly discontinued, people can re-integrate to the community, you know, find new activities, new purpose, new employment, new meeting ...

Q. Okay.

A. ... post-traumatic growth, all of that.

So the focus really was more for that initial piece which was more the stabilization phase. So I did not engage in EMDR, prolonged exposure, or CPT with the member. I did engage in CBT which would be more working on those cognitions, activating through behaviour, some of those interventions.

Q. So is it fair to say that the treatment that Cpl. Desmond received during the residential treatment phase would largely have been the cognitive behavioural therapy, the psychoeducation piece?

A. Psychoeducation being a part of the treatment but with that cognitive restructuring which is part of cognitive process ... cognitive behavioural therapy, apologies.

Q. Okay. Would you have had any knowledge, Dr. Gagnon, of the previous treatments that he had received for PTSD when he was in the CAF or when he was seen at an OSI clinic in New Brunswick before he arrived?

A. I think that might have been ... that information might have been partly present in the summary the team sent to us, but I don't recall what was in that summary, it was a while ago.

Q. You said that you believed the treatment focus at Ste. Anne's has changed since you have left. Can you share with us what you understand those changes have been from returning the member to treatment teams with more skills and strategies. That's what the focus you articulated was when you were there. What is your understanding of how it's changed?

A. So my belief is based on the fact that when I worked there there was starting to be discussions around do we have the time, do we have the space to offer more of that processing. I have remained a little bit in contact with my former colleagues, and so my understanding is there was a little bit more openness and encouragement to engage a little bit more processing.

I think it would have been ... actually, no, I won't speculate. Like prolonged exposure and cognitive processing therapy, they're fairly long treatments. They average about 12 weeks to go through as a manualized treatment, so I'm not sure if that was put in place or not. But certainly a little bit more room for that processing phase was being discussed.

Q. Okay. So there was no processing that was going on, is it fair to say, during your time at Ste. Anne's because of the window of time needed to do that effectively, the 12 weeks?

A. There's always some processing that occurs any time

you're sharing experiences and getting support from peers and thinking about the beliefs around trauma events. But directly as a focus of taking sessions and going for the next ten sessions we're doing processing, you know, deliberately and consistently, no.

Q. Okay. So no prolonged exposure, no EMDR ...

A. No.

Q. ... during that time? Okay. Or cognitive processing. Thank you.

A. Not those manualized treatments.

Q. Manualized.

A. Exposure is something else, but ... yeah.

Q. Okay. Thank you.

You were ... Dr. Ouellette was very clear with us yesterday that his involvement was just with respect to the stabilization program. He did not have any role other than I think to be on call and he said he was never called while Cpl. Desmond was in the residential treatment program.

But I understand that your role started at the stabilization timeframe and them moved forward through to and continued until Cpl. Desmond's discharge from the residential treatment program. Is that correct?

A. That's right, yes.

Q. Okay. And what was your role during the stabilization program period?

A. So stabilization, I usually have a little bit more leeway to provide more individual sessions, facilitating people's entrance into the program, assessing their needs, that psychodiagnostic assessment was performed pretty much as a matter of course. Having an intervention plan that all the different caregivers on the team could really be collaboratively engaged in, so that would have been kind of more that stabilization phase.

Q. Dr. Ouellette shared with us yesterday that one of - and you talked about it a little bit today in your evidence - that one of the challenges for him was that he had prescribed some medication changes and in particular he wanted ... he had prescribed a medication for a mood stabilizer, Topamax I think the name of it was, to Cpl. Desmond and that he was resistant to changes in some existing medication but he flat out was not going to take the Topamax.

He expressed, as I recall his evidence, that - "he" being Dr. Ouellette - that those medication changes were going to be very important in terms of helping to stabilize Cpl. Desmond's

mood to set him up for, you know, optimal success in the residential treatment program.

A. Mmm.

Q. Notwithstanding that, I understand and I think you were part of a discussion around still progressing Cpl. Desmond through that residential treatment phase, Dr. Ouellette indicated that his hope was that in the residential treatment phase, that with group therapy work Cpl. Desmond might change his mind about the medication that had been prescribed.

Were you aware that that was what Dr. Ouellette had been sort of hoping might happen in terms of medication moving forward for Cpl. Desmond?

A. So the general belief that you expressed before, the idea that medication is often put in place so that people can benefit from interventions in an optimal way, that I was aware. Certainly, you know, I think Dr. Ouellette had indicated that that was an optimal outcome.

I'm not sure he shared to me that his hope was that group treatment would facilitate that. I can see why he might have thought that, right, sharing some of your concerns with peers and maybe if they had had positive experiences. But this ... I think that he was hoping this would happen in a kind of

ecological manner, not having us try to kind of direct the group to talk in positive ways about medication or anything like that.

Q. So in either your individual sessions with Cpl. Desmond and/or group therapy that he would have been involved in, would there ever have been a revisiting of the appropriateness of certain medications to your recall, Dr. Gagnon?

A. I think if anything I would have validated some of his frustrations and kind of said that his ... you know, he was allowed to have his concerns. I think that we do try to make clear, you know, risks and benefits. And that belief that we have that this is the path forward that he would have best been able to benefit from treatment would have been made clear to him. But after that I do strongly believe that people should be allowed to make their own decisions and that they shouldn't necessarily feel undue pressure to change their mind. So I think that having expressed kind of what he wanted with us having presented some of the upsides and downsides of his choices, that was kind of up to him at that point.

Q. Okay. But that was in the stabilization program. I guess my question was: Would there have ever been an opportunity - and maybe the nature of the treatment in the residential

treatment program would never have allowed that - to revisit, you know, with the work that was being done in the residential treatment program to revisit medication use?

A. Unless he had indicated to us this is something I want to revisit; I'd like to have another go at this. But even then, you know, as time went on in the residential phase, one of the goals of working on medication right away when people arrive is that you have time to make adjustments.

So I'm ... again, you would have to confirm with Dr. Ouellette, but I hesitate to say that he would have been overjoyed about making medication changes two weeks before departure or one week before departure. So there is a certain time-sensitive element.

Q. Okay. Thank you. I want to move now, Dr. Gagnon, to various reports that were authored by those in your team.

A. Okay.

Q. There seem to be several reports of significance, if I can say that. There's Dr. Ouellette's initial detailed report of May 31st where he provides the diagnosis of PTSD ...

A. Okay.

Q. ... depression, these comorbid conditions, but it's also the first time we see mixed personality traits.

There then is a detailed report which I understand you participated in dated August the 17th, that's the interdisciplinary team discharge report. Do you remember that?
(15:50)

A. Okay.

Q. That's found at page 268 of the exhibit ... the number which escapes me. 254.

A. You said ... (inaudible).

Q. Yes. So it says ... as you can see it says, "Date prepared August 17th, 2016."

A. Okay.

Q. And then if we go to the last page there's a few pieces of information. There's a ... well, there's a section that you've authored, is that fair to say?

A. Mm-hmm.

Q. Do you recall that? Yes. And ...

A. Yes.

Q. ... the report itself looks like it's ... it says "electronically signed on October the 4th, 2016".

A. Okay.

Q. Do you remember how that report comes to be pulled together, Dr. Gagnon?

A. So the person that usually coordinates is Mrs. Hamilton, the social worker, so she would have kind of sent out a message to the different participants in the care, and said, You know we are discharging this member soon; send me your different points that you would like to be included in the summary.

Q. Okay. So do you see the completed report or do you just forward your component for inclusion in the report and then never see it again?

A. We ... I don't remember seeing the completed report, all the different pieces put together. Every week we kind of discuss our different clients in a collaborative way, so we would have ... I seem to remember that we would mention to each other what we thought would be included in that but then, of course, we would send a written version to Mrs. Hamilton ...

Q. Okay. She ...

A. ... for her to include.

Q. She sort of holds the pen to compile the whole report?

A. Mm-hmm.

Q. Okay. We also understand that before that report was prepared there would have been a telephone conference with Cpl. Desmond's outside care team in preparation for his discharge and

continuity of care. Do you remember ...

A. That would be our standard procedure, yes.

Q. Yes, okay. Do you remember participating in that call?

A. I would have participated in that call but I don't remember it.

Q. Okay. No, fair enough. And to the extent that you can remember, generally the purpose of that call, what would you have ... what would the information been shared with the outside care team? I don't need specifics but ...

A. So ...

Q. ... generally for a client who's being discharged.

A. ... generally we'll say kind of what we think were some good treatment gains, what we think were some remaining challenges. You know, what we think our avenues of further investigation or areas that still require treatment. Any concerns we might have would probably be mentioned at that time. Generally, in a general way, that would be the information that would be shared.

Q. And the purpose of that call is to inform the outside team of what to expect when this client is returned into their care. Is that fair to say?

A. That's right.

Q. To have a head's up on what these recommendations are going to be. Is that correct?

A. Mm-hmm.

Q. Yeah. And is that ...

A. Yeah, and to allow them to ask any questions they might have.

Q. Yeah. And to start to action those recommendations. Is that fair to say as well?

A. Potentially, if some need to, yes.

Q. Okay. Because we know that the final report wasn't signed - the final discharge report wasn't signed until October 4th, but given what you've shared with us and what we understand is the purpose of that case call that happened on August the 9th, that information may not have been shared in writing until the beginning of October.

A. Mm-hmm.

Q. But certainly, based on what you're saying - correct me if I'm not understanding it correctly - that information about recommendations, that would have been shared in August typically.

A. In a general fashion I can say typically.

Q. Okay. Thank you. The other two reports that are of some significance I would say are your ... the two reports that my friend, Mr. Russell, reviewed with you this morning and they're both dated December 27th. There's your psychological evaluation report and then your closing note.

Your term at Ste. Anne's came to an end at the end of December is that correct? Because you moved ...

A. That's right.

Q. Yeah, okay. But you had indicated earlier that there were some ... the reason for the delay in authoring those reports is because you needed some time to reflect, I think, and to be confident in ...

A. Mm-hmm.

Q. ... what you were writing in those reports? Okay.

A. To review my notes and review the information I had, yeah.

Q. Did you receive any new information, Dr. Gagnon, from when Cpl. Desmond was discharged on August the 17th to when you would have completed that report?

A. I don't believe so. I don't remember getting any new information.

Q. Okay. And if you had have, it would have been

included in the Ste. Anne's file pertaining to Cpl. Desmond?

A. I don't see how I would have gotten any new information. It would have been fairly inappropriate for me to have access to information for somebody who's been discharged from my care.

Q. Okay. So that ... I will take you to another point. You had recommended and your team had recommended a neuropsychological assessment. That was identified in August.

A. That's right.

Q. And you said earlier this morning that you needed that to rule out ... to be more certain of your diagnosis.

A. Mm-hmm.

Q. So what ... would you ever have expected to get back the neuropsychological report?

A. The only circumstance I can think of is sometimes people come back for another kind of ... another go at a stay at Ste. Anne's, that might have been a circumstance. Although I left so that would have not happened at the end, but that might have been a circumstance that that would have happened.

But no, my expectation would have been to kind of ... I've pushed inquiry a little bit further with this kind of information now what are the conclusions.

Q. Okay. So you would ... if you had stayed and if a neuropsych assessment had been done, you would never have expected to see the results which would ever have allowed you to finalize a more definitive diagnosis?

A. And I wouldn't have retroactively gone back and changed a report, because I would have had to see the member again to make sure my information were up to date.

Q. Okay. So those four things we talked about, Dr. Ouellette's diagnosis of May 31st, his report, the ...

A. Mm-hmm.

Q. ... interdisciplinary discharge report and then your two final reports of December 27th, where do you understand that each of those reports went after they were completed in terms of being provided to Cpl. Desmond's external team?

A. So do you mean what's my understanding of what happened to them?

Q. Yeah, where ...

A. So ...

Q. What's your understanding of what the process would have been in terms of where they should have gone, if anywhere?

A. So my understanding is when a client concludes their stay at Ste. Anne's, that summary with the vital information,

then gets sent to the referring team.

Q. And when you say the summary with the file information, is that the discharge report?

A. If that's the name. I believe that's what the name officially is, yes.

Q. Okay. So outside of that discharge report, is it your understanding that that's the only document that gets sent back to the outside team?

A. Unless there's a specific request, I believe so.

Q. Okay. So if the diagnosis of mixed personality traits was not referenced in that discharge report, is it fair to say that Cpl. Desmond's external team or any member's external team would never know about that diagnosis because they wouldn't receive either the May 31st report from Dr. Ouellette or your December 27th reports?

A. I'd have to look at Dr. Ouellette's assessment to see and then compare with ... actually, sorry, I'm not going to do that; I won't speak to, you know, what he meant. But, you know, when you say a personality trait, for instance, impulsivity would be something that might be a personality trait. So if in my report I say impulsivity is a concern for the member then I don't necessarily need to describe it as a personality trait for

that to be reflected.

So, for instance, in my summary I believe I raised my concern with emotional regulation and emotional volatility, and so that is the essential information from my report which I believe needed to make its way to the external team.

Q. Okay, but in terms ...

A. So it's a des- ... oh sorry, go ahead.

Q. No, you finish. Sorry, the lag.

A. So ... yeah, exactly. So it's the description of the difficulties I think need addressing without necessarily putting a tag on them, that make their way to the external treatment team.

Q. Okay. So in terms of the specific diagnosis that we know that Dr. Ouellette provided of mixed personality traits and your specific diagnosis in your December 27th report of borderline personality traits, if that's ...

A. That's not a diagnosis.

Q. Okay, that was not a diagnosis. That was just a flag?

A. No. Exactly. This is ... when I say "borderline personality traits" I am describing them by saying difficulties with emotional regulation and similar concerns.

So a borderline personality disorder is a diagnosis, which

I did not make because I was not confident that this was present. Therefore, I would not want that to be reflected in the summary report because even if I did say I suspect borderline personality disorder; I believe this may be present, I would realistically have concerns that then people take that, fly with it and then that's a tag that gets put on. I have seen that happen in the past. So I prefer to describe, you know, narratively, what my concerns are. And so the concerns, the area for work, the areas that need to be worked on and that require treatment gets carried to the external treatment team. So that is, in a sense, why I believe the summary is important. **(16:00)**

Q. Okay, thank you. We have heard throughout the evidence over the last week and then this week, Dr. Gagnon, examples of treatment providers seeing Cpl. Desmond experience dissociation. Did you ever experience any dissociative events or experiences with Cpl. Desmond when you were in either a group session or in individual session?

A. So dissociation ... again, I apologize if I'm offering too many technical details, but dissociation, like pretty much any other difficulty, would be on a continuum. So the average person suffering from mental health condition might experience

dissociation. So emotional numbing when faced with difficult news, a difficult situation, that could be considered dissociation. So I think that a determination needs to be made.

So to answer your question, yeah. I think that, you know, when Mr. Desmond kind of described a little bit of that loss of control, that might've been dissociation. When he talked about healing, like, he was experiencing some sensory reminders of his deployments, that might've been dissociation. But you always want to consider, on that continuum, is this something that is recurrent and persistent enough to require individual clinical attention or should that be expected to subside in the course of treatment for trauma.

Q. Okay. Did you ever observe Cpl. Desmond having flashbacks while he was in session with you?

A. No.

Q. Okay. I want to ask you a very specific question. It's because we've heard through family members that Cpl. Desmond expressed concerns that the people who were in the program with him were seniors. They were a lot older. So I want to back that ... give you that and I want to go back.

A. Hmm.

Q. You said during your time there, you would've had

about 15 to 20 patients who went through the residential treatment program. How many people would've been with Cpl. Desmond during his time in the residential phase of the program?

A. I'd really have to have access to the files to answer that. I really don't want to give you erroneous information.

Q. Okay. But it certainly wouldn't have been any more than 15 to 20.

A. At the same time?

Q. Sure, yes.

A. Oh, I believe ... oh boy, I'd have to confirm. I think there are six or eight beds at Ste. Anne's.

Q. Okay, yeah.

A. So, no, there would never be 15 people at the same time.

Q. Okay. And the ages of those individuals that you would've seen, between 15 and 20, can you give us some context if any of them were seniors, as has been, you know, conveyed by some family members that they understood from Cpl. Desmond?

A. I'm really not trying to evade the question. I think the most accurate I can be is I saw both younger members and older members, so I think I've seen a wide range of ages. But I wouldn't feel comfortable giving an average age.

Q. No, and fair enough. And certainly, when you say "older" ages, what would the oldest age be that could have possibly been there?

A. Oh boy. Again, best estimate, 60s?

Q. Okay, thank you.

My last series of questions, Dr. Gagnon, relate to the PTSD and the mixed personality trait. So is it fair to say that there was never any doubt that Cpl. Desmond had combat-related PTSD when he showed up?

A. Not on my part.

Q. Okay, thank you. And that that was as a result of a combat mission that had taken place a significant period of time before he ended up at Ste. Anne's. This was ... we understand he was in Afghanistan in 2007.

A. 2007.

Q. Yes. So nine years later, he is experiencing combat-related PTSD. And so we take from that that that means his PTSD was prolonged and chronic for that extended period of time?

A. I'm not sure when symptoms began to emerge, but certainly he seemed to have been dealing with symptoms for a while, yes.

Q. Okay. And I believe you said that his anger outbursts

would not be uncommon with patients with PTSD?

A. I would not consider them uncommon, no.

Q. Okay. I think ... and I just, again, I'm capturing my recording in some of your notes. You said his inappropriate expressions of anger and anger outbursts were a diagnostic criteria with a lot of people with PTSD.

A. So in the last category, which is kind of that hyperactivation category, irritability and outbursts of anger are a diagnostic criteria, yes.

Q. Okay. And in addition to those criteria and symptoms of PTSD, we also understand that there were these mixed personality traits. The mistrust, the ... but I think you said impulsivity could be as a result of PTSD as well?

A. Could be.

Q. Yeah.

A. There's a lot of overlap between some of these different difficulties.

Q. Symptoms, yeah. It's hard to tease them out as being allocated to either PTSD or personality traits. Is that fair to say?

A. Mm-hmm.

Q. Okay.

A. That is fair to say, yes.

Q. In any event, there were a host of issues that primarily fell under the emotional regulation that were going to need further work for Cpl. Desmond when he was discharged from Ste. Anne's. Correct?

A. That's accurate, yes.

Q. Yeah. And is it fair to say that it's not really ever the expectation that somebody would come through the residential treatment program and be completely finished and not need any further treatment or follow-up?

A. That would be ... if that were the case, that would be an outlier as opposed to the rule.

Q. Right. You would expect folks to come through the program, to be discharged with recommendations to go back into their external care team for implementation and continuity of care. Correct?

A. That was the usual process, yes.

Q. Okay. And that's why implementation of those recommendations would be so critical for their future success back in community and back in their external circle of care.

A. We wouldn't recommend things if we didn't think that they would be beneficial for the member, yes.

Q. Thank you, Dr. Gagnon. I appreciate your time today.

A. Thank you, Ms. Miller.

THE COURT: Thank you, Ms. Miller. Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(16:07)

MR. RODGERS: Thank you, Your Honour. Good afternoon, Dr. Gagnon.

A. Good afternoon.

Q. I'm Adam Rodgers and I represent the personal representative for Cpl. Lionel Desmond, and so I have a few questions for you as well. Thank you for your endurance throughout the day here.

Doctor, I just want to start with just a general sense of the Ste. Anne's facility, thinking of it from the perspective of a soldier, a combat veteran, attending the facility. It would seem, Doctor, that there's different levels of needs when it comes to a combat veteran. Some would return home and just go home. Some would have a little bit of counselling and peer support maybe. Some would have more long-term counselling. And then there are others that, the more serious cases that don't get resolved in those manners that would be referred to or would

attend at a residential facility like Ste. Anne's. So is that fair that this is a facility for those that haven't been able to reach the resolution through other means?

A. So the reasons why people would refer clients to us could be varied. Sometimes it would be kind of more psychosocial barriers. So, for instance, having a few young kids at home. So there's so many responsibilities that there's no time to engage in psychotherapy and kind of all the time is being taken by family responsibility. There might be an arrangement where support is provided to the family and then somebody comes to Ste. Anne's. Sometimes people have trouble engaging in what's called "exposure". So, for instance, for some people, it becomes very anxiety-inducing to leave their home. And so without a therapist with them to support them in those exercises, that might be difficult. Whereas in Ste. Anne's, because that's part of the program, that might provide that extra, or that different type of support that's needed.

So I wouldn't say that how long people have been dealing with things is necessarily the defining criteria for if they get referred to Ste. Anne's or not. I think there's specific benefits to that residential aspect of treatment which external teams saw as being beneficial. Does that answer your question,

Mr. Rodgers?

(16:10)

Q. It does. It's interesting because, you know, for some situations then, the residential option may be the first and best option, whereas for others, it may be that they've tried other options, counselling in the community or just on their own, and then they've discovered that they, or somebody has discovered that they need the residential care.

A. I'm not sure if the first option would be Ste. Anne's to discover that some of these specific needs are in place that might be better addressed by residential treatment. Somebody would have to assess them and potentially try to give care in another setting to find that there would be that specific need. I don't know if I've ever heard of anybody, in the time that I was there, that that was kind of the first thing that was suggested.

Q. In fact, it may be more accurate to think of it as the last, best option for certain individuals. Certainly, one might think that in Cpl. Desmond's case, where he had tried other ... where other options had been tried with him, you know, in the community care and different psychiatrists, psychologists, over the course of several years, and that this may have been

characterized, or it might be accurately characterized, as his last, best option.

A. I'm not sure who would characterize that in that way.

Q. Well, if I could put it this way, in broad, very unscientific terms, if this didn't work, what was next?

A. I find myself ...

THE COURT: All right. Sorry, Mr. Rodgers, you might be able to ask the question in a little different way, but I'm going to suggest to you that you shouldn't be ... that kind of a question that's just wide open and asking the doctor to speculate on an answer, okay, because clearly, whatever the outcome was at Ste. Anne's, he was going to be referred back to whatever the treating team was.

MR. RODGERS: Yes.

THE COURT: And so really, you should be asking the treating team, the treatment team, you know, what if, or what would happen, as opposed to Dr. Gagnon whose team was just kind of a step along the way here.

MR. RODGERS: Certainly. It seems like a significant step along the way. I will rephrase that, though, Dr. Gagnon.

THE COURT: I'm not saying it's not important.

MR. RODGERS: Sure.

THE COURT: But the question that you're asking is not ... isn't, in my view, particularly the way you asked it - is not a question you should be asking Dr. Gagnon. Thank you.

MR. RODGERS: Thank you, Your Honour.

So, Dr. Gagnon, I want to ... so I'm thinking of in terms of intensity and having a team approach, a team on hand, to help a combat veteran. Would there be a further option that you could think of that would be more intensive with a bigger team or something more in-depth?

A. Mr. Rodgers, I feel like you're equating kind of this residential treatment as the ultimate thing that can be tried, and if that doesn't work, then nothing will work. Maybe I'm speculating to what you're trying to say, but I feel like that's what I'm understanding. And what I will say and as a very general way, different people respond to different modalities and I can't think of a situation where I would ever even think to myself, well, if that didn't work, nothing will.

You know, people ... situations change. They evolve throughout their lives. The stressors in their lives change. They develop skills. They connect well with certain providers who have, you know, a certain approach that meshes well with their own personal style. So I think it behooves us as

clinicians to try different avenues of treatment and not necessarily ... and again, I may be reading into what you're trying to read me, but necessarily think there's nothing better than this big care team that will work for the member because, you know, what people will respond to varies widely.

Q. That was basically what I was trying to ask you, Doctor, so I appreciate ...

A. Okay. So I did understand that correctly.

Q. I appreciate you framing it in that way and I appreciate the answer as well because that is helpful.

So in other words, while this intensive residential program may be completely appropriate in some cases, for other individuals, it may be a step along the way or it may not be what they need specifically.

A. It might ultimately be unhelpful despite us piling on all this great care onto people. Sometimes for people, the group approach is not appropriate for them. It's too intimidating. Or it's not the right time for them to engage in this kind of treatment.

So really, every treatment is so individual. We have kind of these very broad overarching best practices, but at the end of the day, we're just trying to figure out what fits with

people. What might be helpful? And what's helpful today might not be helpful with what's helpful in two months from now. So it is really always kind of checking in and figuring out what's helpful now. More care, less care, different care.

Q. All right. It seems, Doctor, when Cpl. Desmond left Ste. Anne's ... First of all, maybe you can help us with this. We're saying that he left early. Is there a typical timeframe that we would normally expect for somebody staying at a residential treatment facility or staying at Ste. Anne's?

A. Mm-hmm. May I ask you why we're saying that he left early?

Q. Well, I think the expectation was that this was a six-month program.

A. Again, I might just need to review my files, but duration varied according to how long the stabilization phase was, so that varied according to some members. And then the residential phase was usually, I believe, around eight sessions. So I'm not sure ... maybe it's my own recall that's faulty, but did somebody from Ste. Anne's say that he left early because of a specific reason?

Q. Well, the report we have, Doctor, is that he wanted to leave in order to return to Nova Scotia before the school year

started to spend some time with his daughter.

A. Okay.

Q. And that, in fact, he left prior to the completion of the program. Certainly, when we review the conclusions from the providers, it seems that the treatment was incomplete, or at least there was certainly plenty of recommendations for further treatment. I'm not sure how you'd characterize that.

A. So I think that when you mentioned that school year kind of jogged my memory a little bit but I don't think that ... certainly not from my point of view and maybe it's best if I just speak from my own point of view.

Q. Sure, that's fine.

A. Certainly, from my point of view, having those recommendations in place would not have been an unusual outcome. I think that his treatment gains were limited and that was, you know, something that we were aware of and we wanted to make sure that, you know, they were capitalized on down the road. But having recommendations at the end of treatment is ... would be a normal part of the process.

Q. One of the recommendations you made ... and I won't go through all of your ... we've seen the discharge report which is at page 268, so we don't need to go through all those

recommendations but certainly one of them was a detailed neuropsychological evaluation because of the complexities of Cpl. Desmond's presentation. Would that be a fair assessment of that recommendation?

A. So that recommendation was made because of some cognitive difficulties that I observed which may or may not have been simply kind of the result of symptoms of PTSD, but having doubts, I wanted to make sure that that was properly assessed to see if there were any other underlying causes.

Q. Dr. Gagnon, you may not be aware of this, but Cpl. Desmond didn't have any contact with any mental health professionals until October 24th when he left Ste. Anne's, so over two months later when his wife, Shanna Desmond, brought him into the emergency room.

Given the recommendations that you made, would that two-month gap be a concern? Would it be a big concern? What consequences would you foresee as a result of that? Or I should say just what do you think of that time gap and the potential problems that would bring?

(16:20)

A. Well, I don't know about that. I don't feel that I can really speak intelligently as to that time gap. I don't

know what the member was up to during that time gap. I don't know what his needs would've been during that time gap. You know, the way things usually happened was that when those recommendations were made, they would return to an established treatment team. Again, correct me if I'm misrecalling if that's not what happened. As you mentioned, I don't have a lot of details about what happened after his stay at Ste. Anne's. But I believe the member moved, so in these times of transition, was it expected that he not have kind of those contacts? I don't know. I feel like I can't speak intelligently to something on which I have so little information.

Q. That's fine, Doctor. We'll hear from other witnesses as to why that gap occurred. But given the number of recommendations that were made upon his departure from Ste. Anne's, does it surprise you that those weren't picked up right away and that a continuity of care developed? Or would that have been your preferred outcome that that continuity of care developed certainly within the coming weeks?

A. Our ideal process which we usually see is that an external team refer to us, we refer back to them, and it's a fairly seamless process.

Q. All right. So who at Ste. Anne's ... or how does that

work then? Like who coordinates with the outside care team to ensure that that takes place or is that left to the outside care team to pick it up from where Ste. Anne's has left off?

A. Usually, it's done kind of in a collaborative manner, so different people communicate at different times. For instance, we all participated in that phone call to inform the external team of what our conclusions were. So that was part of that effort to make sure that, you know, our work was then taken up and continued down the road.

Q. Okay. So is there, to your knowledge ... and I recognize that you're not there at Ste. Anne's any longer, but is there somebody there who follows up on that to ensure that somebody has an appointment or somebody has, you know, a case worker who's doing certain things?

A. Well, usually we know they have a team and a case worker, so there is that understanding that they'll be kind of taken up afterwards. So I'm not sure. That's not my piece. Again, I really don't want to speculate and give you information that's false. I really don't have a lot of information on that.

Q. That's fine, Dr. Gagnon. I'll ask other witnesses. I asked you because your title is care coordinator and so I don't know the limits of that title and whether the care coordination

ends at a certain time ... well, ends at discharge, or whether there's any continuation or follow-up after somebody has been discharged.

A. So passing the information to the external care team would be part of making sure that that treatment then gets picked up but certainly I don't keep treating clients after I've discharged them from my care.

Q. And there's no systemic follow-up or review to see how that's gone out. I guess in terms of even informing the treatment within Ste. Anne's to say, Well, okay, these people have gone off to care in this way and our recommendations have been followed and it's gone well. Well, that means we made good recommendations, and in this case, it's gone in a different direction. Like to reinforce or reinform the decisions that have been made within the facility, is there any follow-up for that? Just educational purpose?

A. When we provide care, the benefit is ... the lens is, that it will provide a benefit for the member. I'm sure that this has come up with your discussion with different mental health and health providers, but there are stringent rules about what kind of information you then are allowed to have about members once they've transitioned out of your care. And so I

think that there is that real preoccupation with making sure that I don't have eyes onto private health information which will not allow me to ... which I have no purpose in seeing.

Q. All right. That's fine, Doctor.

Okay, I'd like to switch topics and talk a little bit about the family unit and the family situation for Cpl. Desmond. It certainly may have seemed apparent to you at the time, of course, that there were difficulties, or that there might be difficulties, on him returning to the home. It seemed to be of some benefit to the team to hear from Ms. Desmond, from Cpl. Desmond's spouse, to gain some insight. Is there any thought, or do you have any thoughts, of incorporating the family further into treatment, into residential treatment? Whether it's even having them on-site for a few days, observing the facility in more depth? Do you see any benefits to doing something like that?

A. I mean I like to base my opinions on science, so I'd have to review more literature to see if there might be a benefit to that. You know, giving some psychoeducation to family members does tend to seem useful but, you know, if you ask me if, could this possibly be helpful, I think the answer to that is always going to be, It's possible.

Q. Of course, yes.

A. But I think that there's sometimes this idea that adding on things will be helpful and that's actually not always the case. So we want to be careful that if we do add things on, we've got solid reasons to believe that this would actually provide a real benefit. I couldn't cite any literature to you right now supporting that. I'd have to do my homework, I guess.

Q. No, that's fine, Doctor. It just struck me that the conversations that were had with Ms. Desmond seemed to help provide some insights or some further insights. And then preparing the family for ... you know, knowing that the soldier is moving back home, having some way of preparing the family and maybe educating them as to what their spouse has just gone through in terms of treatment might have some benefit.

A. I can definitely understand where you're coming from in asking me this question. Again, I would encourage you to have the lens of, when people confide things in me in therapy, I am always then very prudent about what happens to this information.

So as much as you're saying there could be benefits to this, sure, that's possible. There could also be negative outcomes to this where people would feel inhibited in what they

could tell us, knowing that they would be almost in a summary report provided to their family. So if you're asking me, Could there be benefits to this, my answer is always going to be yes. Is there something that should systematically be in place? I'm not sure.

Q. No, it's interesting, you know. Thank you, Doctor. Just in terms of that relationship, do you recall if, in any of your discussions with Cpl. Desmond, you know, he has some complaints about his spouse and has some suspicions about her. Did it ever come up that, you know, in many ways, she was the perfect spouse for him. A nurse, somebody who was going to be ... have a good earning potential, someone who stuck with him for years, somebody that could look after him and was taking care of him. Was that a ... did anybody try to sort of turn the table on him and try to persuade him otherwise that, in fact, he was quite fortunate to have a spouse as he did?

A. So when I have interventions, I try to encourage people to have balanced views of other people. I think it would've been inappropriate of me to suggest that she was the perfect spouse for him. I didn't know her. Maybe on paper they sounded good, but maybe they had fundamental values differences or personality differences that wouldn't have made them a good

match. So I don't encourage people to make certain life choices. I think that would be overstepping my boundaries as a clinician. I try to encourage people to see risks and benefits, to take a balanced view, to look at what might be a realistic perception, and those kind of considerations, but I would not find myself suggesting that somebody is a perfect spouse for somebody else, especially not having met them.

(16:30)

Q. Well, a perfect spouse might be ...

A. I understand what you were saying, right ...

Q. ... might be a term that ...

A. ... that there was ...

Q. ... doesn't really exist in reality. But anyway, at least you understood the question.

Doctor, in terms of the exit strategy such as it was, you know, are there discussions at Ste. Anne's or do you recall discussions not even particularly in Cpl. Desmond's case but of well, if we're sending somebody back home or if we're letting ... you know, if somebody is leaving, you know maybe they're not ready to leave or maybe we need to tell somebody well, this person should be held against their will involuntarily and under involuntary care. Is that something that came up in your

experience at all or is there ways to deal with those kinds of situations that you're aware of?

A. You mean involuntary care because somebody ...

Q. Well, if they were considered too dangerous to be left out on their own. I'm not suggesting that would have been the case in Cpl. Desmond's case, but when you're transferring people over to a provincial system, are there protocols in place or discussions that take place in that respect of well, should we let this person go or what options do we have?

A. So if in the course of treatment at any point anybody determines ... anybody gives us a strong reason to believe that there is imminent risk to themselves or others then we're acting at that moment.

So I don't think it's ever occurred that right at the end of treatment ... I mean, I guess technically right at the end of treatment there could be this major psychosocial stressor and the person becomes highly suicidal and then right ... the discussion could be had about an involuntary hold. But otherwise our role is to make the recommendation to try to make sure that they are supported in their return to their community wherever that is.

But, sorry, I think I'm misunderstanding the question. I

feel like you're suggesting that there's a place people could be put if we're worried about them.

Q. Well, not in Ste. Anne's. I guess I'm just thinking of, you know, if somebody is having an episode they may just decide to leave Ste. Anne's, you know.

So I guess I'm thinking about what criteria might you be using and it may be a difficult thing to answer in a broad context, but is it ...

A. Imminent harm to self or the other is the only reason that we're going to limit somebody's right to their own choices. Unless somebody gives me a really ... if somebody got up in the middle of group therapy and said, You know what, this place isn't for me, I don't think I'm getting benefits from it I would of course try to have a discussion with that person to see what kind of state they're in.

But unless I'm getting really reasons to believe that somebody, including themselves, is in danger, I respect people's free will to do ... to make their own treatment decisions, that's a fundamental right that people have. And so I would not try to ... I mean, I again would try to give, you know, risks and benefits and potential consequences, but I would not try to tell them what they should do with their lives.

Q. In this case I know you've given evidence on the discussions that were held with Cpl. Desmond's care team, his outside care team, but if ... is it ever the case or in your experience, that, you know, you had a bad feeling about the outside care team or you didn't feel confident that that care team was in place and ready to act? And, you know, if that circumstance has arisen what have you done? Has it been try to persuade or you just still let the person go if they want to?

A. So maybe if I could give you a hypothetical, would that be helpful maybe?

Q. Sure.

A. Okay. So, I don't know, we have somebody in care. They're returning home, they've just gotten married to somebody they barely know and there's a lot of conflict in the relationship and me, I'm thinking to myself, Oh boy, you know, this relationship doesn't look very healthy. If ... you know, if that person returns into their relationship maybe things won't go so well and hopefully they'll be well supported when that happens.

You know, people's lives may take difficult turns. There is no action that I'm going to take based on some speculation that things might not go well for somebody. I'm not even sure

what my options would be.

Again, really my biggest asset is to be able to say these are the things that I think this person would really be benefiting from to support their return, but this kind of speculation about things that might happen in the future and, therefore, we should do something now, that's a bit of a slippery slope.

Q. Sure. No, I understand that, Doctor. Thank you. Just in terms and just a few more questions, Doctor.

You identified that Cpl. Desmond was having some trust issues with his care team and you've explained, you know, how that may have manifested itself or how it may have arisen. But do you ever make a connection between that and his cultural background, racial background? You know, here he is, an African Nova Scotian soldier in Quebec with, you know, treatment providers that he doesn't know and are of a different cultural background.

Was that ever discussed or any thoughts on how to address that, you know, perhaps through connecting him with another veteran that may have been able to talk to him about the treatment and work with him that way? Was that topic raised?

A. So I think that there's potentially multiple parts to

that question. I think the first part of that question was when you said, you know, do you think that his skin colour might have had something to do with the distrust he was experiencing with his care team now. Was that right? Did I understand that?

Q. Yeah, that's part of the question, yeah. And I don't mean to imply it but it's certainly a factor I think we need to explore.

A. I don't think there's anything inappropriate about exploring that factor either.

Q. Yeah.

A. So I think that, you know, having him had ... excuse me, I'm having trouble with my words, it's a bit late in the day. Him having mentioned to me that in childhood that was one of the reasons that he felt, you know, put aside or apart from others. I think it's not unreasonable to imagine that, you know, skin colour would be something that would be on his mind. I think that as clinician it's important for us to always think about reasons why people might feel like they are on the outside, they are being not included into a group.

And I think while there is some benefit I think to having people join communities where they can feel like they can talk to people who have had similar experiences, whether it be

discrimination for skin colour or any other reason, I think there's also some benefit in me as a clinician trying my best to understand where people are coming from and, again, the length of treatment is limited when it's a bound treatment. But certainly if I have a client that I feel has some specific concerns whether it be about gender or skin colour, disability, any of those kind of concerns, it's worth addressing transparently and having a real open discussion about those kinds of rejections. I think that's a conversation we're having more and more and I think that's a great thing.

Q. Doctor, Cpl. Desmond had identified to ... The meeting where you and Ms. Hamilton were going to call ... were trying to call Ms. Desmond, I understand you left the meeting, but afterwards, I don't know if you saw the note it's on page 263 if you need to go to it, but Cpl. Desmond had identified that he had had negative reactions to some malaria pills that he took while in Afghanistan. And I wonder if he identified that to you in terms of reluctance to take medication that was provided to him by the military.

And, you know, I know you're not military, but from his perspective he may not have made that distinction.

A. Perhaps. He never mentioned that to me, no.

Q. Okay. Thank you. And would there be an option if ... and I take what you said earlier about the idolization then ...

A. Devaluation.

(16:40)

Q. ... devaluation and so maybe once he got to a point where he was mistrusting the staff, rightly or wrongly, you know, we don't want to judge that part, but would there be another facility you might consider transferring him to a different place, another residential facility?

A. So I think that what you're suggesting is once trust is broken it might be a better option to send somebody off somewhere else?

Q. Well, given his particular diagnosis. I mean, maybe not across the board because that might be unworkable. But in his particular case was that a consideration of sending him to a different location?

A. Again, you know, I tentatively mentioned that there might be some borderline personality disorders, but indeed if we are dealing with borderline personality traits I would suggest the exact opposite, because this pattern of that light switch I can trust you, I can't trust you and there is no middle ground, we want to break that cycle to say you can repair when there's

distrust. You can repair when there's disappointment. People are fallible. People make mistakes. People hurt your feelings, intentionally, unintentionally, you do too. And we can have this imperfect relationship where we have conflict and we work to resolve conflict and we go forward from there.

So I would say distrust is ... I mean, if a client were to say to me there's nothing you can do, I won't ever trust you and I don't want to be in treatment with me I respect that of course. But if there's any opportunity to repair any kind of therapeutic breach, I'm all for that and I would work very strongly. I think that's a strong, very worthy therapeutic experience that helps people progress from these positions of all or nothing.

Q. So in other words, yeah, you would break the pattern rather than exacerbating it by or by feeding into it by sending him somewhere else or by recommending somewhere else?

A. Yeah.

Q. Interesting. Well, Dr. Gagnon, thank you very much.

Just I want to say, I mean, I've gained some good insight from your testimony today so I appreciate it. You must have wished you had more time with Cpl. Desmond given what you've identified from his conditions and your observations.

A. I would have hoped that we would have had more times for more gains, but ... And certainly knowing how things turned out I think that we can't all help but wonder what else might have happened. But I'm happy to think that I was able to provide some information that was useful to you. Thank you.

Q. Well, I do thank you and those are all my questions. Thank you, Doctor.

A. Thank you, Mr. Rodgers.

THE COURT: Potentially two more. Mr. MacKenzie?

MR. MACKENZIE: No questions, Your Honour.

THE COURT: Thank you. Ms. MacGregor?

MS. MACGREGOR: No questions, Your Honour.

THE COURT: All right. So, Dr. Gagnon, all the counsel have asked all the questions ... oh, I'm sorry. I was going to ... Ms. Ward but I see that it's not Ms. Ward so ...

MS. GRANT: I'm sorry. I'm sorry, Dr. Gagnon ...

THE COURT: Ms. Grant, I'm sorry.

MS. GRANT: ... you thought you were done.

THE COURT: I'm sorry. I apologize Dr. Gagnon, you're not quite finished.

CROSS-EXAMINATION BY MS. GRANT

(16:43)

MS. GRANT: Thank you. Dr. Gagnon, can you hear me okay?

A. I can hear you well, yes.

Q. My name is Melissa Grant and I represent the Government of Canada, so we're representing the various federal entities, including VAC and the Canadian Armed Forces which you're familiar with, and I guess I'll start with that question. You were at Ste. Anne's for about a year or so, correct?

A. That's right.

Q. And then when you left you went to work for the Canadian Armed Forces. And so I was just wondering as a first question why did you take that job and what do you like about your job?

A. So I took a job because it's been my dream job since I started my doctorate. So I was overjoyed when I was offered a position. What do I like about my job? I don't think that you want to take the time to spend with me for me to describe everything I like about my job.

I like a lot of the things that I liked at Ste. Anne's. I like the team approach. I love the clientele. I think it's

very rewarding work. Yeah, I really love my job. Yeah.

Q. And turning to the kind of ... the healthcare for veterans and active members of the CAF, we understand that people who are RCMP members or veterans have access to OSI clinics in provinces and then a facility like Ste. Anne's. Is that your understanding as well?

A. That's my understanding as well, yes.

Q. And then like those ... like Ste. Anne, like the OSI clinic and like in a setting where you work, there's a multidisciplinary approach?

A. Mm-hmm.

Q. Okay. And in, I think, sort of speaking generally about mental health access and services available to people, in civilian non-veteran and non-CAF populations, so, you know, everybody else, I guess, access to mental health services can be, I guess, hindered by cost in the sense of if a service is not covered by the province then, you know, if you don't have insurance then it's your own out-of-pocket expense.

A. That's right.

Q. And so on that sort of basis, would you agree that veterans and CAF members generally have more access to specialized mental healthcare because they don't have to pay out

of pocket?

A. I have a little bit less experience with CAF because, as you mentioned, I only spent one year at Ste. Anne's and I was very kind of limited, and I saw one aspect of the care offered to active military members and veterans. But in my work with CAF I would definitely say that, you know, for instance one of the things that I like to mention is when I worked on the civilian side in different environments, having access to a psychiatrist is often very difficult or getting in touch with the family doctor versus ... again, one of the things I do love about my work is if I feel that I need to have a consultation with ... or the opinion of a psychiatrist then I can very easily ask for that referral.

If I need to have a discussion with the doctor, they make themself so easily available to have those discussions, so I feel like that really facilitates this team collaborative care approach which I think is a good asset.

Q. Thank you. And turning to the issue of suicidal and/or homicidal ideation, I guess you would ... or would you agree that it's not uncommon for individuals who have a mental health diagnosis to sometimes have suicidal ideation?

A. I would say that that's not at all uncommon, no.

Q. And sort of looking at us as a, you know, lay audience, if you will, if people see sort of suicidal ideation in a report or even potentially homicidal ideation, that kind of sparks a kind of reaction in people of like what ... you know, almost like a sort of like do you press a panic button. And so I guess, you know, if you're dealing with this on a daily basis, do you have any, I guess, comment on the ... like that part of living with a mental health diagnosis? That if someone expresses that to you.

A. I think that that panic button analogy that you're making is something that I do use in the sense that when I assess people part of my job now is regularly assessing people to see what's happening with them, what diagnosis they might have. And that's something that I say in a pretty standard manner: I'm not going to panic if you tell me that you have suicidal thoughts, these happen to a lot of people. Let's talk about them. Let's see what's happening.

And I think that this kind of matter-of-fact approach to suicidal or homicidal thoughts really allows people to be more open about them. It normalizes them as something that people struggle with and that we can try to have an impact on.

And again, you know, I tell people we're going to have two

very different conversations. If you tell me that these are things that in the past or presently go through your mind, that worry you, that you struggle with, that scare you sometimes or that sometimes you kind of hold close to you as kind of if nothing else works at least I have this amount of control, that's fine, you know, we'll have people help you manage these and that's okay.

And then we're going to have a very different conversation if you tell me, you know, I'm not sure if I'm going to be able to keep myself safe until tomorrow morning, right. Those are the circumstances where I have the obligation to break confidentiality.

Q. Right. Thank you. And we learned a lot today about some of the terms and you explained those terms really well. I just want to return to some of those. One of them was dependent personality traits and looking at the file with respect to Lionel Desmond it seems, and whether you would agree with this suggestion, that he was maybe a bit immature in his view towards relationships or almost superficial. Would you agree with that?

(16:50)

A. I'm not sure I would use the words kind of immature, superficial, but I think that it was maybe underdeveloped.

There was this kind of idea of what his family life would be. And it was difficult to get details if he had thought about, you know, what are you going to do for this to go well, what might go wrong and then how could you respond to that, and to really flesh out this understanding of some of the challenge, right. Again, moving away from this perception that things are all or nothing. Either we're doing well, you're committed to me, you love me and then we're okay, or there's a break in this relationship and it was wrong or bad all along.

Q. All right. I just move home and everything will be fine, that kind of thinking?

A. I think that was certainly his hope.

Q. One of the notes talked about Lionel Desmond sort of laughing and being jovial at meetings, group meetings, and that's something we've heard from his family members. And people who knew him, say before he went to Afghanistan, would describe him as happy-go-lucky. Would describe him as like Tigger and he would even say now I'm an Eeyore, as that ... you know, that metaphorical picturesque language that you said he employed a lot.

I'm just wondering if you could comment on that particular affect of being jovial, kind of maybe the class clown as

potentially whether or not that affect actually is reflective of your inner feelings?

I guess I'm thinking of someone like Robin Williams who was a comedian but, you know, underneath all that there was some struggle. So can you give us a sense of that?

A. I can't necessarily speak to him, you know, before I saw him but, you know, when he was at St. Anne's with us, I tended to see that a little bit in the framework of his avoidance, you know.

When he would be in session and he would be all animated and talking about very superficial or very cheerful things, you know, I often felt that it was his way of saying let's talk about the good stuff, let's talk about the things that are going well, which I completely understand he wanted to do, but a little bit maybe as a way to avoid some of the difficulties, you know, and wanting to connect.

I think that when he made jokes and, you know, when he was laughing and making comments to people in the group, he was looking for that connection, but I think that sometimes it was a bit of a way to cope.

Q. Thank you. Switching to the topic of the neuropsychological evaluation that was a recommendation of

yours. Just, I guess, a question about the logistics of these things and wondering if that had not been conducted by, say, the end of December 2016 would that have been unusual in your line of work?

A. Not necessarily. Unfortunately, depending on where you are, and even in the NCR, having access to a neuropsychologist can be a bit of a lengthy process; they do often tend to have long wait lists. Assessments are long to complete. So I believe at that point he was in rural Nova Scotia?

Q. Yes.

A. Yeah. So, you know, we've had ... sometimes it takes several months to find an appointment with the appropriate professional. So while I agree that that's not optimal ... I mean, in an ideal world I would have plenty of neuropsychologists at my fingertips when I need them, that would not necessarily be unusual unfortunately.

Q. Okay. And we've talked a little bit today about this treatment for Lionel Desmond is looking more long term.

A. Mm-hmm.

Q. And so would you expect that he would be maybe working with someone whether it's in the community or OSI, whatever the

circumstance, to have long-term and intense psychotherapy?

A. I'm not sure what you qualify as intense psychotherapy.

Q. Well, a lot of the work that you couldn't get into at Ste. Anne, the trauma-focussed kind of therapy.

A. I would agree with the long-term part. I think I would agree that this would be an ongoing process ideally with somebody that could see him on a long term. And, as I was discussing with Mr. Rodgers, to have that back and forth when there are, you know, breaks in the relationship that we can repair and work on having kind of that nuanced view of other people.

Q. And this next question may be not one that I guess makes sense but I'll ask it anyway. You can fix it for me.

So the neuropsychological evaluation I would, I guess, ask that that recommendation is not indicative of a view you had that Lionel Desmond needed inpatient treatment following his discharge from Ste. Anne?

A. So are you suggesting that if I made the recommendation is the expectation that he would be in an in-treatment care?

Q. Correct.

A. That's what you're asking?

Q. Yes.

A. No, that would that not. If I had believed that what he absolutely needed was inpatient treatment care then I would have made that recommendation.

Q. Thank you. And on the ... we talked a little bit about the usual course where you explained you usually get a referral from a treating team and then in the normal course the person would go back to that treating team. And so we know ...

A. That's correct.

Q. Thank you. And so we know in this case that this was a bit of an unusual situation and you'd agree with that?

A. So I ... again, I ... this was a while ago and I don't want to get things wrong. I believe what happened is he moved while he was at Ste. Anne's, is that correct, or right after?

Q. It is. I'll have to paraphrase the testimony from the New Brunswick OSI team, but they saw the sort of a state of flux. So often he would be moving kind of back and forth between New Brunswick and Nova Scotia and it wasn't always clear to them sort of if he was staying or going back or that sort of thing.

During your time at Ste. Anne, had that ever happened with

another patient where they did not return to their ...

A. Not that I remember.

Q. Okay.

A. No. That would have been atypical.

Q. That would have been atypical.

A. (Nods "yes".)

Q. And if ... it's our understanding that there's a group of people, the team, that meets to determine whether someone is appropriate for an admission into Ste. Anne, is that right?

A. That's right.

Q. And if that had been something that had been brought to the team's attention that, in fact, Lionel Desmond would not be returning to the New Brunswick OSI team, is that something you would have taken into account?

A. I don't remember if that was mentioned. I don't think it was. Certainly, we would like to make sure that this person returns to a care team that's been established, right, because that is a lot of change for somebody to deal with in a short time. One external care team, then residential treatment and completely different care team, I don't see a lot of continuity there.

So I think that I would like to think sitting here today

with hindsight, that had we known that maybe we would have maybe waited for a little bit more period of stability so that there wouldn't be so many changes in a short time but, again, hindsight, that's just me sitting here today.

Q. Right. Thinking about maybe what I guess I would call sort of the misconceptions about mental health and what ... do you have any comment on the idea that ... I guess I would call it maybe stereotype is more accurate that people with a mental health diagnosis such as PTSD are more prone to violence against others?

A. I mean, I think that's a stereotype that's in popular culture a lot. I think that one thing that also tends to be a ... let's say a ... I think battleground is too strong a word, but something that I advocate strongly to anybody who will lend me an ear anywhere, is that there's this very negative perception of anger, like it's a bad emotion and we shouldn't feel it, and I think that that's not the case.

You know, evolution has helped us to maintain anger because it's got a purpose and a lot of our role is often to help people use their anger in a productive way to ... You know, as I explained during my testimony, I don't think it was at all inappropriate for Mr. Desmond to be frustrated by some of the

things that happened to him, that's part of life and community. And you really get gains when you manage to sit down with people and explain why you're feeling these type of feelings; what can we do as a compromise.

And so I think that, you know, when people have ... when people display anger I think that it does tend to make us feel a little bit more uncomfortable. I think that that's often misunderstood as something that's very destructive and it can be obviously.

The current proceedings we know that anger can lead to very destructive things or can be involved in the process of very destructive things. But I think that that's ... I would say that that's probably part of that kind of general misconception that having anger and the anger involved in PTSD kind of leads to people being violent towards other people when, in fact, I've treated plenty of people with PTSD by now and that's not the rule.

Q. And on that topic, it has been suggested that people with mental health diagnosis should not have access to firearms and I'm wondering if you could comment on that.

A. Wouldn't that constitute discrimination?

Q. I would say yes to that question but I'm just asking

for your sort of your view as someone who deals with this.

A. I don't make those kind of determinations, right. I'm not the one who's going to be assigning the right to have a permit. I think that there are very specific reasons why people would be denied a permit for a weapon, but to say that anybody who's got a diagnosis of mental health.

(17:00)

And I mean, is it current? Is it past? Anybody who's ever had mental health issues can't ever have a weapon ever again? That's going to be almost everybody in our current situation. Post-pandemic that's probably going to be everybody. So that would start to be problematic.

So, again, I'm not making those decisions but if I look at it from a point of view is should we decide in an absolute way what a person can or can't do based on mental health I would very strongly be opposed to that.

Q. Okay. And in the setting where you currently work as treating CAF members, would you kind of carry that analysis over to CAF members who have a mental health diagnosis, but might have a hunting weapon at home?

A. Yeah. And I treat plenty of active military members who have weapons at home and go on ... both on the civilian side

shooting ranges and on the military side shooting ranges, and unless I have very specific concerns, that's not something that worries me.

Q. And in your current job at the CAF, just because you do work at the CAF I have to ask the question of whether, in your experience, CAF members are able to access their health records if they need to?

A. Yeah. So things have changed a little bit in pandemic time, but usually there's ... in the (inaudible) site there's a little window which is med records. You come in, you say what you would like to have, the (inaudible) signs off on the documentation and it's in your hand. So usually it's a fairly simple process.

And actually, I was going to say things have changed during pandemic but I think it's been simplified because now you just send an email to med records and you have the records.

Q. Thank you. Thank you, Dr. Gagnon, those are all of my questions. Thank you for your time and your patience.

A. Thank you very much.

THE COURT: Well, before I move towards concluding again, Mr. Russell, do you have any further questions?

MR. RUSSELL: We thought about it, Your Honour, but no.

EXAMINATION BY THE COURT

THE COURT: Well, this is your ... perhaps your one and only opportunity to ask Dr. Gagnon a couple of questions.

So I just have a couple of questions, Doctor, and I'll be brief. I know that Ms. Grant had asked you a question in relation to firearms licenses, and I know that at the end of the day the decision to grant a firearms license are not generally falls ... it's the responsibility of the chief firearms officer in any given province to do that.

When the chief firearms officer has, and there's an application that has to be completed and there's a requirement to disclose whether or not a person has had any mental health treatments within a set period of time and generally it's five years I believe. And at the time the individual discloses that to the chief firearms officer, you'd understand that they then have an obligation to conduct a review, and to obtain as much information as they may require to satisfy themselves that the individual is an appropriate person to possess firearms given the public and safety concerns that are imposed on the ...

A. Sure.

Q. ... chief firearms officer by virtue of regulations

and by the legislation.

So my question is, at that point in time all of the health records, the mental health records, that you have in relation to a particular person who may be applying for a license, would you see any real objection to having that information made available to the chief firearms officer so that it would assist them in making the determination that they have to make in regards to suitability? They have different parameters than you might have.

And would you also be open to have a discussion with a chief firearms officer with regard to what might be in those records as part of that licensing process? Or any comment you might have in that regard.

A. I would strenously object to somebody having access to all the records. You know, I treat people who have trauma, who describe to me horrible things that have happened to them that sometimes they have never disclosed to anybody but me. And I think that the idea that somebody would have eyes on to this information, which, you know, I don't know, sexual abuse, childhood sexual abuse, completely non-pertinent to whether they should have a firearm I think that would make me ethically very uncomfortable.

Q. Thank you.

A. I think that ... and perhaps you can guide me, Your Honour, if that's what you were ... you're getting at. I think the legitimate concern that if somebody has a mental health disorder that includes very significant suicidal ideation or homicidal ideation and then putting an extra barrier so that somebody doesn't impulsively hurt themselves or others, I think that that's appropriate to try to keep people safe.

I'm not sure. I think with my client's consent I would be happy to confirm or deny if that person has those kind of risk factors. I think that that would be providing just the right kind of information to make an informed decision without violating the client's right to privacy so ...

Q. That's why I asked the question, Dr. Gagnon, because of your background and your experience and knowing the types of information that you have and how that could impact on any given individual. I don't promote one or the other but I just ... I need to ask the question to see what your opinion is.

A. Absolutely.

Q. So I appreciate that, thank you. And I have one last question for you.

The terms of reference for this particular Inquiry were set

by the Minister of Justice back in February of 2018, and one of the terms of reference ... I'm just going to read what it says here to you. And it says: "Whether Lionel Desmond and his family had access to appropriate Domestic Violence Intervention services."

I know that there was some discussion about some events and whether those events ... so I'm going to ask it my own way I guess, whether any of those events would signal that there was a potential for domestic violence. That was generally how the questioning went and I asked you a particular question.

So at this time my question would be this: During the period of time that you were dealing directly with Cpl. Desmond and had access to the information that was available at the clinic, did you see anything that at that time - I appreciate there's two perspectives, there's the perspective from then and the perspective from now, but just dealing first with the ...

A. Sure.

Q. ... perspective at that time, whether you saw anything that would suggest to you that there was a need for a domestic violence intervention services?

A. I think that, you know, Your Honour, you've hit the nail on the head. It would feel completely ridiculous of me to

say no today knowing how things evolved and ended but I also have to be fair and I extensively reviewed my notes in preparation for today and the only thing that he described to me in terms of his conflicts with his family was yelling and shouting and kind of this general kind of outward displays of anger. Would I feel comfortable labelling that as domestic abuse? Would that mean that any time that you shout at your spouse you're engaging in domestic abuse?

I mean, is that optimal? Of course not. Is that a healthy expression in a relationship? Of course not.

Knowing what I know now do I think that could there have been some benefit in pro-actively seeing if there was some resolution to do with this domestic conflict? Yes, of course. But with only the information available to me back then, I'm not sure if I would see it in a different light without this new information.

Q. All right.

A. I'm sorry, you promised to be brief and I'm being very all over the place. I hope that answers the question.

Q. For me it does. I understand.

A. Okay.

THE COURT: All right. Dr. Gagnon, and just ... so we

are finished here and I want to thank you for your time. I know that you spent some considerable time preparing for today. You've clearly, you know, gone back over your notes and put some time and some effort into looking at Cpl. Desmond's circumstances as they relate to the events that occurred and during the period of time that he was with you in Ste. Anne's.

We certainly appreciate your time. It's very valuable to us. It's very important for us to have as much kind of first-hand information and circumstances that are available to us. We have documents, but it's always more valuable to actually have an opportunity to speak to the people that were engaged with him at Ste. Anne's. And so thank you very much for your time and we appreciate it. Stay well and ...

A. Thank you. And thank you very much for allowing me to participate in this process which I really think is an important one.

THE COURT: All right. Thank you, Dr. Gagnon.

WITNESS WITHDREW (17:11 HRS.)

THE COURT: All right, so we'll close for the afternoon then, Counsel. Thank you.

COURT CLOSED (17:12 HRS.)

CERTIFICATE OF COURT TRANSCRIBER

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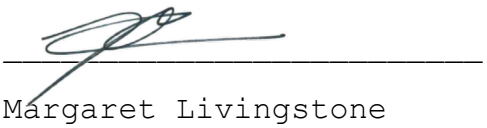

Margaret Livingstone

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