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: November 29, 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

Stewart Hayne, Esq.
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

INDEX

EXHIBIT LIST

NOVEMBER 29, 2021

COURT OPENED (09:34 hrs.)

THE COURT: This morning we are scheduled to hear from the Health Association of African Canadians. Previously, there was an application to participate. It had been filed by Ms. Sharon Davis-Murdoch, who is co-president of the Health Association of African Canadians. In addition, we have Mr. Robert Wright, who is the executive director of Peoples' Counselling Clinic. We have Ms. Lana MacLean, who is a mental health and emotional support counsellor, as well as Cynthia Jordan, who is also a mental and emotional support counsellor.

I had previously indicated to Ms. Davis-Murdoch, who is actually the applicant, that this Hearing is in the nature of judicial format. It will be necessary for each of the individuals to be sworn and we would hear from the applicant. The format is a little different. We have a paper that was filed on behalf of the Association. It has been marked as Exhibit 347 and I think counsel would have a copy of that as well. I think there will be some questions led by Inquiry Counsel. We will try and direct the flow of that evidence in that particular way. There will be some flexibility but,

primarily, that's the way we will deal with it this morning.

EXHIBIT P-000347 - BRIEF - HEALTH ASSOCIATION OF AFRICAN CANADIANS - NOVEMBER 22, 2021

So good morning, everyone. Thank you for attending this morning. I think the first order of business will be to have each of the individuals sworn, please.

LANA MACLEAN, sworn, testified:

ROBERT WRIGHT, affirmed, testified:

SHARON DAVIS-MURDOCH, affirmed, testified:

CYNTHIA JORDAN, affirmed, testified:

THE COURT: Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good morning, everyone.

PANEL: Good morning.

MR. RUSSELL: Thanks for helping out with this Inquiry. Your report and evidence, I'm sure, is going to assist Judge Zimmer at the end of the day.

So I guess we could start by, I'll start with maybe some introductions with everyone. If you could just tell us a little bit about, I guess, who you are, what your occupation is. I'll start with Ms. Davis-Murdoch.

I guess, Ms. Davis-Murdoch, would you tell us a little bit about yourself and your occupation and your role with the Health Association of African Canadians?

(09:40)

MS. DAVIS-MURDOCH: Thank you, certainly. Good morning, everyone. I'm Sharon Davis-Murdoch. I am a founding member and the co-president of the Health Association of African Canadians. I have been, I would say, officially retired from the Nova Scotia Public Service where I served in many policy roles, finally in the position of policy advisor to the Associate Deputy Minister for Diversity and Social Inclusion for Health Systems.

I am, since retirement, I do work in the community and help to lead as part of the executive of the Health Association of African Canadians. I also serve on the Dartmouth General Hospital Foundation Board. I work with the Halifax Immigrant Partnership and continue to work in health policy and social justice broadly.

MR. RUSSELL: Thank you. Ms. MacLean, we do have a copy of your *CV*. It's Exhibit 351. It won't be my intention to review everything, obviously, in your *CV* but just as we did with Ms. Davis-Murdoch, if you could give us sort of an outline of a little bit about yourself and your current occupation.

EXHIBIT P-000351 - *CURRICULUM VITAE* - LANA MACLEAN

MS. MACLEAN: Thank you. My name is Lana MacLean. I am a practising clinical social worker with a background and a

specialty in the treatment of mental health and addictions with people of African descent, particularly African Nova Scotians, Carribean, and new immigrants. I have a small clinical practice here in Halifax and between 2011 and 2012 I was on the Board of the provincial government's Together We Can, Mental Health and Addictions Strategy. I've served on that Board until the completion of the strategy. And, presently, I am a Board member of the Nova Scotia Foundations Grants.

MR. RUSSELL: Thank you. Ms. Jordan, we have a copy of your *CV* at Exhibit 354, much the same, we won't review all of the details necessarily but if you could tell us a little bit about yourself and your current roles and occupation.

EXHIBIT P-000354 - *CURRICULUM VITAE* - CYNTHIA JORDAN

MS. JORDAN: So my name is Cynthia Jordan. I'm a mental health nurse. I've been nursing in mental health and addictions since 2007. I've had various roles within the Nova Scotia Health Authority within the addictions and mental health. I'm a charge nurse with management over the years. Day treatment program lead. Currently, I am in the role of clinical lead for Pause Mental Health Line that is run out of the North End Community Health Centre.

I just transitioned from a federal government job with the

Department of National Defence. In that role, I was a Mental health nurse in the addictions department treating members with addictions and trauma, PTSD, amongst other mental health disorders.

I also write cultural impact assessments under the Nova Scotia Institute of Justice and I serve in various roles within the community in terms of volunteering within the African Nova Scotia community.

MR. RUSSELL: And, Mr. Wright, I guess you've probably heard the question by now. So, sir, I wonder if you could provide us a little bit about yourself and some background.

MR. WRIGHT: Sure. My name is Robert Wright. I'm a practising social worker. I have a registered private practice, which has been registered since 1997 in Nova Scotia. I have specialties in the area of direct practice, forensics, and trauma.

I have worked in a range of areas. I've worked in education, health. I've worked in child welfare. I've worked in Correctional Mental Health, where I was a mental health specialist at the Washington State Penitentiary. And I have been, for the last 11 years, the executive director of ... I've been leading my own private practice which has evolved into the

Peoples' Counselling Clinic.

In 2008 and 2009, I served on the Mental Health Commission of Canada's Task Force on Diversity and was supporting the publication of the Issues and Options paper, which was the national review of the Mental Health system in Canada's response to serving immigrant, refugee and ethnocultural Canadians. I suppose that will suffice for now.

MR. RUSSELL: Okay, thank you. So what I had planned to do is sort of break it into sort of sections, I guess, to make it easier for us to navigate this morning. The first series of questions is going to be in relation to sort of background and the Health Association of African Canadians.

So I guess the first question I would have is, What is the Health Association of African Canadians and where is operations within Nova Scotia?

MS. DAVIS-MURDOCH: So I think that would be appropriately answered by myself. The Health Association of African Canadians is a nonprofit health association based in Dartmouth or, more specifically, Cherry Brook, Nova Scotia. We were established in 2000. Our mandate is to inform health issues concerning African Canadians. These include education, research, health care delivery, and policy reform. The vision for our organization is

thriving healthy African Canadian communities in Nova Scotia. And the mission is to promote and improve the health of African Canadians in Nova Scotia through community engagement, education, policy recommendations, partnerships, and research participation. I would say that we have a view and vision, as well, to become a national organization, though we are and have been focused in Nova Scotia since our establishment.

And so within our mandate as well is to create or to increase awareness of health issues in Nova Scotia, to increase representation of people of African ancestry across all levels of the Nova Scotia health system, to advocate for and promote the implementation of health system data with race, ethnicity, language, and other diversity identifiers, to increase research productivity, to increase community education and advocacy, to promote dissemination of research findings to wide audiences including community members, researchers, and various levels of government, to develop the strategic partnerships to build community capacity, to inform policy development and make recommendations for health system policy change and action, to build a strong and sustainable internal structure, and to identify and apply lessons learned locally informed by systemic, cultural competence.

So in short, I suppose, I can tell you that we identify, people of African ancestry among those who face health disparities and inequities and consistent with literature on the social determinants of health and growing understanding of the structural determinants of health that is, the things that make us sick, all of both the social and structural talk about that. You know, the governing processes, the economic and social policies that govern us, working conditions, housing, education, all of those things that are touched or incorporated by both social and structural determinants. And so we know that people of African ancestry are among those marginalized groups, who are likely to be fully aware of the risks for certain diseases and disorders, suffer from higher rates of chronic disease of which mental health is a chronic disease, have reduced life expectancy, access care less frequently, and feel less comfortable with the quality of care that they receive than those who are well represented or are represented in the health system. We work within an Afrocentric philosophy and we continue to work for the well-being of our people through a culturally competent approach that is transparent, trustworthy, respectful, accountable, and established with integrity and honesty.

Q. I'm wondering, Ms. Davis-Murdoch, I guess if you could tell us a little bit about examples of perhaps partnerships that your organization has, maybe in Nova Scotia's mental health or in a health care context and through Family Services resources and how they're administered through the Province. So I guess could you tell us a little bit about partnerships you may have with those entities and structures within Nova Scotia?

(09:50)

MS. DAVIS-MURDOCH: Well, I think, first of all, it would make sense to point out that the Health Association of African Canadians is one of many organizations who are members of the Decade of People of African descent or the People of African Descent Coalition, of which Mr. Wright is an executive member. And so our connection to Black mental health professionals of all kinds comes in that collaboration.

As I mentioned when I was asked to introduce myself, I worked in the Public Service for over 24 years and, in that time, all of my work was in policy. So my policy connections to Black mental health providers, to many policies, strategies, including the Together We Can Strategy, which was established in 2012. I was one of the people instrumental in informing the need for that strategy and then working alongside, if you like,

who were developing that, who were aware of the recommendations coming from that, and then in some measure, trying to implement those recommendations over the years since 2012. As well, our connection to the Nova Scotia Justice Institute as part of our work with the Decade of People of African Descent Coalition is well known and I think will be better articulated by my colleague, certainly, Mr. Wright.

And so when you talk about partnerships that the Health Association of African Canadians have had I think, you know, they would be too numerous to mention but whether you're talking about government at every level, we have collaborated with the Province, we have collaborated with the federal government, we have collaborated with community-based organizations, the Alzheimer's Society, for example, Diabetes Canada, national organizations, you know, and Nova Scotia Health, certainly, when it was Nova Scotia Health Authority and now it is Nova Scotia Health. So over these many years, our collaborations have continued since our establishment.

Q. So you've pre-empted my question and I'm going to direct it towards Mr. Wright. If you could tell us a little bit about, I'm trying to understand the dynamic of the Coalition and how that comes into play with the health association and,

ultimately, service delivery models within Nova Scotia.

MR. WRIGHT: Well, the African Nova Scotian Decade for People for African Descent Coalition is just that, a coalition of Black organizations and individuals across the province who initially came together several years ago to respond to United Nations informants who were here in Nova Scotia going across country to really give an update on Canada's response to meeting the human rights expectations towards people of African descent. And after that time, we decided, since we were all assembled in responding to the United Nations, that we should keep working together to that end.

So there are more than 30, almost 40 organizations that are part of the Coalition and many other individuals. And so the Coalition has working groups, for example, in the area of justice, child welfare, health, economics, and the Health Association of African Canadians is certainly taking the leadership in the health work that is done on behalf of people of African descent in Nova Scotia.

And when I think of collaborations, the Health Association of African Canadians, I think of the work that we did in 2010, 2011, 2012, where as a result of the mental health review in Nova Scotia, the Health Association of African Canadians was

approached to work with the Department of Health to improve mental health service delivery for people of African descent in Nova Scotia. And the Health Association took the leadership in building the team that did that work.

So the Coalition continues to try to work provincially, to maintain a collaboration of people across the country in those various sectors.

Q. Thank you. I guess we will move from sort of broad into specific as we go. I think it's probably best for our benefit to sort of orientate ourselves to sort of some broad understandings in context and background. What I had planned perhaps to do to keep it as easy as possible for the record would be, I'll go by the way it's presented on the screen, so starting with Ms. MacLean, Ms. Davis-Murdoch, Ms. Jordan, and then Mr. Wright.

So my first sort of question is about Nova Scotia and resources as it stands right now. And I guess, Ms. MacLean, I will start sort of with you and then, if there's anything to add, we would go in that sort of order with the Panel, if that's suitable. Does that seem to work for you?

MS. MACLEAN: That's reasonable.

Q. Okay. So I guess my broad question is, as it stands

in 2021, are there culturally specific mental health and intimate partner violence Family Services resources for African Nova Scotians in 2021?

MS. MACLEAN: Not to my knowledge in terms of specifically culturally relevant service delivery within the health care system itself or within the Department of Justice itself. However, I know my colleague, Mr. Wright, can speak more specifically to the initiatives with the IPV community. But in terms of clinical supports to meet the unique and culturally specific needs of the African Nova Scotia mental health and addictions, there is no specific programs or service delivery within, whether it's adolescent mental health or adult mental health, to my knowledge.

So, Mr. Wright, I am hoping maybe you can piggyback and speak a little bit to the intimate partner violence piece.

MR. WRIGHT: Sure. So just by way of context, the Peoples' Counselling Clinic that I direct is a partner in the services that are provided around the domestic violence court here in Halifax and, as a result, my clinic is a member of the Interagency Committee on Family Violence in Metro.

And I would say that there is no, as Ms. MacLean suggested, no real focussed culturally specific service delivery to African

Nova Scotians in the area of intimate partner violence and sexual violence, although there has been recent movements where there have been collaborations between the Association of Black Social Workers and the Elizabeth Fry Society to begin to study this issue.

And I know that ... I am a member of a research cluster at the Dalhousie Schulich School of Law called CCLISAR. Don't ask me the acronym but it's largely a group of legal researchers who are studying the application of law to improve response of the criminal justice system to sexual violence and intimate partner violence. And one of the research projects that we are undertaking was simply a literature review around culturally specific initiatives for Black women, particularly. And, again, that review found that there were no real systemic initiatives. Again, like I say, there are some partnerships. There have been some forays into this work where we've begun to see the need but there has not been yet established a program. There is a small group of Black women who are taking it upon themselves to advocate for these services but as yet these services do not exist.

Q. Okay. Ms. Davis-Murdoch, or Ms. Jordan, I guess, anything to add to that? If there isn't, that's totally fine.

(10:00)

MS. DAVIS-MURDOCH: I think that was well said.

MS. JORDAN: I agree.

Q. My next sort of question is, we talked about sort of there isn't really any structure in place right now within Nova Scotia for culturally specific resources in those areas. If you could give us a sense of what it would look like in both, examples of what it would look like in both health care in mental health context and as well in a family services intimate partner violence context.

MS. DAVIS-MURDOCH: Well, perhaps I will, if that is acceptable, I will speak about the health piece and then ask Mr. Wright to talk about the domestic violence aspect or intimate partner violence aspect.

What we talk about and have talked about in the Health Association of African Canadians with respect to recommendations for the health system has always been that we would like to see the development of cultural competence through training that is inclusive of in factors such as anti-Black racism as part and parcel of that cultural competence training. And what we mean by cultural competence is the awareness, knowledge, skills, and policies needed to serve people across diversity. When we talk

about people of African ancestry specifically, the way that cultural competence shows up in service delivery is through culturally specific applications in the way that work is done, in the way that clients are understood.

Cultural competence talks about having a sense of the history and lived reality of the people that you are serving. It talks about understanding that one size does not fit all and that's where cultural specificity comes in and it talks about the need for planning and service delivery that responds to the unique needs of people.

Anti-Black racism is a social and structural determinant of health. It is impacting the health of people of African ancestry in all ways and the constant, and I know that my colleagues have expertise in this area so I invite them to add to this, but the stress of living with anti-Black racism, you know, microaggressions on a daily basis and high level structural racism, which means that you have a system that doesn't meet your needs, that isn't represented by people who look like you at all levels let alone at the highest level of the system. That has an oppressive effect on people and, indeed, affects their health.

And so when we talk about what we would like to see,

certainly like to see training, education required of those people, whoever they are, who provide service to people of African ancestry. That is a broad system-wide number of people, right. So that that becomes part of how you do business in the health system. That is part of your competence as a health professional. And, indeed, the language of cultural competence comes from the health professions, even though it is applicable across all areas of government, all areas of society, but it comes from health because the understanding of competency is that one has to maintain competency. One cannot continue to practice without maintaining competency. So it isn't something that you do and you have it forever. It is an ongoing learning process, lifelong learning that there's always something new to learn, there's always an area in which you need to develop. There are people who we are serving who have different life experiences, who have as marginalized people experienced childhood trauma, lived with systemic racism. And so understanding that in how you serve them is very important.

So we want to see training. We would like to see culturally specific approaches. We would like to see ourselves in, we talk about it all the time, see ourselves represented even in the health messages that are provided by government. I

am also co-manager of the Association of Black Social Workers and Health Association of African Canadian COVID-19 Response and Impact Team. So throughout the pandemic, we have been available to people of African ancestry providing information that is culturally specific, providing town halls, providing resources in communities because we understand the importance of cultural specificity and we understand that service provision is not one size fits all. And I think our work has informed not only work in Nova Scotia but across the country because we have put that first. And, indeed, culturally specific vaccine clinics are an example of an outcome of that thinking.

So just to explain what that looks like and how it is realized, if you like, the training, the approach, the application in the health system. So we would like to see people build this competence throughout their careers. We would like to see service that is culturally specific in nature. We would like to see research that prioritizes our needs so that we can understand those things that are happening in community. Understand perhaps in a comparative way what happens in urban Nova Scotia as compared to rural Nova Scotia and I think this case or the fatality certainly points that up in many ways.

So cultural competence understanding isn't just about race

though race is foundational. It is also about gender. It is also about sex and gender identity. It's also about rurality and those who live in urban areas. It's about age. It's about class. It's about difference and understanding how all of those things impact the health of people.

So, with that, I would ask Mr. Wright to talk about the other aspect.

Q. Sure.

MR. WRIGHT: If it's okay, I'll defer to Lana, if she'd like, to talk about culturally specific services around mental health and maybe I'll talk about intimate partner violence.

MS. MACLEAN: Sure. Thank you, Robert, and thank you, Sharon, and everyone. So I have the privilege of working predominantly with the African Nova Scotian community around mental health service delivery and there are specific cultural adaptations that we can do as clinicians with conventional treatment services or treatment delivery models that the conventional system fails to put some operationalization into. So there are programs and services, service delivery models that when leveraged within the context of cultural capacity and cultural competency, that mental health clinicians can develop and deliver more effective mental health services delivery.

So that would be looking at an adaptation in our screening tools for people in community groups like Family Services. They're usually very standardized. You could look at the screening tools used, the assessment tools used, and the delivery of treatment, particularly whether it's individual therapy or couples therapy. There has to be an acknowledgement of race in the room and not to give some consideration to that as a clinician, it's a failure to actually develop and implement culturally responses to people who are coming to you, whether it's a mental health crisis or a family crisis. So those skills and tools and delivery of the mental health and addictions has to take into consideration as well the community structure in which people are living and thriving or surviving it.

(10:10)

So, as Ms. Davis-Murdoch spoke to, the needs of mental health service delivery in rural Nova Scotia has to have a different particular cultural adaptation because the rural experience of Black people is different than the urban experience of people who are of African descent. Access to resources. If you are aware, that means 80 percent of Black mental health clinicians reside in HRM, if not a higher proportion of those.

So looking at cultural adaptations, access to services in the mental health delivery models needs to be actually pivoted to give consideration to the unique needs of certain communities. So that if we look at the Upper Big Tracadie/Sunnyville/Guysborough community, for example, where access to mental health services is not just about transportation. It's also about supporting the cultural literacy development within those communities so they have a better awareness of what mental health looks like, what crisis looks like, when people are having a psychiatric break, to when people are experiencing anxiety. So people of African descent show up differently around anxiety. We show up differently when we're in a psychiatric crisis. And to have a cultural understanding of what that looks like requires a tremendous amount of cultural humility in our practice. So there has to be some humility. There must be cultural capacity and cultural competency development and there has to be at least at minimum some access or resources, particularly in rural Nova Scotia, to how do we pivot to provide a service delivery model to those communities that leverages something like what we're doing today, virtual care, or so people have access to those supports.

What does it look like for Family Services associations in

this province wherein 90 percent, if not all of their staff, are people who tend to be of the dominant culture and the recruitment and retention of people of diverse communities to support the work that they do. So the networking of the community groups that conventionally service these communities, particularly women who are trying to leave or trying to navigate intimate partner violence in the African Nova Scotian community, there are all these very culturally specific nuances around the level of individual capacity versus the community's capacity and resiliency.

So the use of certainly mental health services in the communities of the Guysborough/Tracadie/Upper Big Tracadie communities, and Lincolnville, tend to have always pivoted to the church and, you know, accessing, having relationships and community connections to those kinds of resources is one way that you look at what we call cultural adaptations to divide and support people, like networking and mentorship within those facilities.

So I think if we look at mental health service delivery, we need to take into consideration what does that look like from cradle to grave or from, you know, from birth to end of life in terms of the delivery of services and the culturally specific

needs based on people's presentation. And that is, again, I think from a mental health perspective requires some level of cultural competency building within the individual practitioner and within the organization, but more importantly, to looking at how do we develop cultural adaptations to treatment models and access to service delivery, particularly to rural communities and leveraging best practices to ensure that that happens.

Q. Thank you.

MS. MACLEAN: Mr. Wright?

MR. WRIGHT: Yes, thank you, Lana. I guess my colleagues have spoken a lot about the kinds of things that are necessary. If I can go back to your question, you were saying what would a system look like? Well, I think that you have in Ms. Murdoch, you have a health policy specialist, and in Ms. MacLean, Ms. Jordan, and myself, you have clinical specialists. And I think in 2012 when we were involved, the Health Association of African Canadians was involved with the Department of Health to develop an African Nova Scotia Mental Health and Addiction initiative, we put forward a vision for what a better system would look like. That system had three deliverables. We were going to conduct two conferences to provide the training that Ms. Murdoch spoke of needing, culturally specific training.

So I would say what would a system look like? A system would look like a system that regularly housed province-wide conferences and training that brought practitioners together to consider the mental health, addiction, and intimate partner violence and response needs of people of African descent.

The second deliverable was the implementation of an on-line curriculum that would be a baseline for providing all mental health clinicians with expertise or know-how in terms of how to respond to the very things that Ms. MacLean spoke to.

And the third deliverable was the creation and the maintenance of an African Nova Scotian mental health and addictions network of professionals. We did effect the conferences, only the two. The conferences were not continued after the termination of the project. We did create the content for a curriculum but the Department of Health did not sustain the resources to translate that curriculum into an on-line program that could be housed, maintained and delivered by the regular system of mental health upgrading or training that is done strictly in the system. And in terms of maintaining the African Nova Scotia mental health and addiction network, when the project ended, the Province and the health authority disbanded that network. The network that exists today is being

maintained and supported by private individuals as volunteers. It is not being sustained by the health system.

So I would say that there are a couple of things that what would a system look like. Well, although there are Black clinicians employed across this province, there is no formal network or centre of excellence for Black mental health service delivery as there are in other areas of practice. For example, there are specific clinics around attention deficit disorder, autism spectrum disorder. There is a special initiative for sexually aggressive youth. So the Province does have the capacity to create centres of excellence that bring together experts around a particular topic area or population and that that centre of excellence then can be the centre of providing the capacity for helping all clinicians to increase their understanding and to have a place to refer to when they have a client that they may not understand.

So the creation of a centre of excellence, the support of the development of the network of mental health clinicians who are Black who can support that network, and I think a centre of excellence on intimate partner violence for people of African descent.

There is a network of largely women-serving agencies in

this province that make up the Transition House Association of Nova Scotia and to, in some places, there have been small initiatives to have that system be responsive to the needs of Black women. I would say that largely those services have not well served women of African descent in this province. And I think that members of the Transition House Association would say so.

And so there is a need for a centre of excellence for intimate partner violence in Black community and that might be in the form of a specific Black transition house that would serve as a centre of excellence that could serve and be a reference point for all transition houses across the province, for example.

And the last thing I would say is that one of the things that is essential is that we not just apply mental health practices to Black people in a way that is just re-packaging things that already exist for white people. As Lana said, there are very specific ways in which mental health manifests itself and I would say that intimate partner violence is simply an expression of problematic mental health issues. So violence is supported by a lack of wellness or illness.

(10:20)

And I think that one of the things we need to recognize is that mental health and intimate partner violence is impacted significantly by systemic racism and racial trauma and that, as we think about people, particularly working in the Armed Forces, we have some understanding of the trauma that exists when one works in that dynamic. I think we are only beginning to take into account the fact that racial trauma in the Armed Forces has a very unique shape and that I think something that we are aware of that currently the Department of National Defence is involved in a class action lawsuit about systemic racism within the Forces and that one of the things we should take away from that is to consider what is the effect of the systemic racism that one would experience in the Armed Forces on one's mental health and how might that affect a person's violence.

So I guess that would be my comments.

Q. My question was ... Sorry, Your Honour.

EXAMINATION BY THE COURT

(10:22)

THE COURT: Mr. Wright, I am going to just interject for a moment because I just want to ask Mr. Wright a question.

Mr. Wright, you were referring to the project, you called

it the project, what was the name of the project?

MR. WRIGHT: I think I was speaking of the African Nova Scotian Mental Health and Addictions Initiative.

Q. Okay.

MR. WRIGHT: That was undertaken by the Health Association of African Canadians after the mental health review in Nova Scotia.

Q. And when you say that there were three deliverables and you mentioned the three of those. Those deliverables were determined by that group or were they developed in some other format or in some other kind of organizational structure.

MR. WRIGHT: They were developed in consultation with the Department of Health. So when the mental health review came out it demonstrated that African Nova Scotians were poorly served by the mental health and addictions system. So the Department of Health came to the Health Association of African Canadians and said, Can you develop a project to help us respond to this need? And so as we developed the contracts, we negotiated these deliverables and these were the deliverables that we thought would help us move the system from where it was in its competence to a greater place of competence.

Q. When did that begin and when did it end? Can you give

me some idea of the timeframe?

MR. WRIGHT: I think it was 2009 to 2012 but, no, Lana's shaking her head.

MS. DAVIS-MURDOCH: It began in 2012.

MR. WRIGHT: 2012.

MS. MACLEAN: 2012 to, we ended, I think, our final report, 2016.

MR. WRIGHT: Okay, very good, thank you.

THE COURT: 2016.

MS. MACLEAN: Uh-huh.

Q. So I take it that the Health Association's support ended at that point, is that the reason why it simply didn't continue?

MR. WRIGHT: Not the Health Association support. The Department of Health and the Nova Scotia Health Authority's support.

Q. Sorry, that's what I meant, was the Nova Scotia Health Authority's support.

MR. WRIGHT: Yes.

THE COURT: And was there ever any discussion or explanation or what the rationale was for discontinuing the support of the Nova Scotia Health Authority at that point in

time?

MS. MACLEAN: To my knowledge, I believe there was a shift in the Department of Health and Wellness. The senior person within that department at the time was championing the initiative had retired and then there was an organizational shift in which the support folks who were championing this with the Nova Scotia Health Authority, there was an organizational shuffle and then we met briefly with the then Director of Mental Health and Addictions, Mr. Trevor Briggs, who said he was going to look at how to continue implementing the program, and then they have never gotten back to us as far as my understanding, Sharon and Robert. They failed to reconnect and they, from my perspective, Your Honour, it didn't become a priority. And now we consistently have been advocating for the re-implementation of those three pillars and there's been so many organizational shuffles that, again, it has not become a priority.

MS. DAVIS-MURDOCH: So if I could, your Honour, the 2012, Together We Can Mental Health and Addictions Strategy happened and it happened and there were recommendations across many areas and certainly the Health Association of African Canadians' representation in the strategy was but one, but one set of recommendations. As happens with many government strategies,

recommendations are put forward and not necessarily implemented.

So that strategy had its recommendations. I'm sure it informed future work of the Department of Health and Wellness. I myself, as I have said, retired from, at least from the public service in 2015. So, in time, there has been more work done or more policy emphasis on mental health and addictions, certainly, but in terms of specific implementation of that strategy, it probably has, you know, either been reconfigured or, as many recommendations in strategies happen, not implemented completely. This happens with government strategies and government programs of many kinds.

THE COURT: Thank you. Mr. Russell.

DIRECT EXAMINATION (Cont'd.)

(10:27)

MR. RUSSELL: Just following up with His Honour's questioning, you did talk about the time and effort that went into the three deliverables and what I take from the information is that it sort of just got left in about 2016 and, for lack of a better phrase, the government might have pulled out of the implementation of their end of, I guess, the deal, I guess, or the arrangement. You've mentioned that the importance of sort

of cultural competence and ongoing commitment to that and the overriding importance. And I guess with every new government, there are comments made about change and perhaps government of the day today has indicated a commitment to mental health. So do you see it as sort of time to revisit with the government, the current government, the deliverables that were researched, developed back in 2012 and move towards that commitment in 2021?

MS. DAVIS-MURDOCH: Well, I would like to ... I certainly would hope that my colleagues will add to what I'm about to say, but absolutely. In fact, we have articulated that, the Health Association of African Canadians, has talked to representatives from the government quite a number of times. Now this is actually, what I want to say is quite a number of times since 2016 but since this new government has been formed, the Houston government, certainly there have been conversations about mental health. We've been asked to talk about the health system generically and we have been involved in, I personally have been involved in two conversations around sort of health policy overall, but certainly mental health being part of that.

Now a point that I would like to make is that as a policy person trained in that area throughout my career, I certainly have also been very aware of government policy development and

promise. And with this new government, there has certainly been tremendous emphasis on mental health and the importance of even a restructuring of mental health has been named. And one thing that stood out and that I have referenced with representatives from the government is that this government wants to boost the mental health and addictions budget by 30 percent. They certainly have opened a specific new office, if you like, of mental health within or connected to the Department of Health and Wellness. I mean that's specific and it is significant in terms of change.

(10:30)

But one of the areas it referenced, it's "the government" referenced during the election and have perhaps referenced it less since but I'm looking forward to hearing more about it, is that they are talking about allowing private practitioners, including psychologists, counsellors and social workers to bill the Province to provide care to those without private insurance.

This is a huge and progressive policy deliverable, should it be delivered, because what that means then is that people who did not have access to this number of diverse, qualified and culturally relevant and culturally competent providers will now have or will have with the funding that government has proposed

an opportunity to see practitioners, to see them more quickly, to see people who look like them and who understand their individual and, as Black people, unique lived experience.

And so I can tell you that we certainly look forward to that as being a policy deliverable and, indeed, we know even in other areas of Canada, that there has been emphasis on one-on-one culturally competent therapy by Black therapists who people can relate to. That there's work going on in Toronto around this where Black therapists are able to help people of African ancestry deal with various trauma, including anger, depression, anxiety, grief, racialized incidents that happen, you know, on a regular basis to our people. All of this impact is acknowledged and is part of the go forward that is happening in Toronto.

So if we could have our providers such as the highly competent people on this, who are presenting with me today be available and be funded by the system what a difference that would make. So that's my ...

Q. Thank you.

MS. JORDAN: And if I could ...

MS. DAVIS-MURDOCH: Yes.

Q. Yes, Ms. Jordan.

MS. JORDAN: And if I could just add to that, the

importance of cultural competent care delivery services is imperative because when folks do not receive cultural competent services it causes further harm. There are actually additional aggressions that happen, people aren't validated and they walk away more frustrated from systems, which adds to the trust or lack of trust within the system.

And folks, particularly people of African Nova Scotian descent, when they reach out for services and they don't get the sense that their stories are actually authentic or true or even validated, it is causing further injuries and further frustrations for individuals. so this type of work is really imperative.

And I would say that, you know, in terms of policy I've worked in the federal government for some time and I've seen policies that are great policies, but oftentimes on the ground folks struggle with implementing those policies. How do they work? How do you implement policy into practice, into every day work? That's often a challenge.

So, in terms of, you know, the policy or the cultural responsive training that Robert spoke about in developing the online and the conferences and creating organization oftentimes I believe systems get stuck. They have the information but they

have no idea in terms of implementing those policies. And it sounds like, you know, there is certainly room for that in terms of recommendation, in terms of, you know, figuring out what do policies look like in practice in terms of cultural competent care.

Q. Thank you. My next sort of area that I'd ask that we explore is in terms of we touched upon it sort of barriers to mental health and domestic or intimate partner violence family resources.

I'm wondering if you could sort of generally define for us what is systemic racism and how does it exist within the structure of (1) mental health service delivery in Nova Scotia; and (2) with domestic violence intervention resources and family intervention resources?

I phrased it obviously saying it does exist within those structures, certainly correct me if I'm wrong, but I guess it's ... so the question is sort of twofold: Is what is systemic racism and how does exist or does it exist within those two entities?

MS. DAVIS-MURDOCH: Robert, would you like to take this on?

Q. And certainly ...

MS. DAVIS-MURDOCH: You have a definition right near where

you are.

Q. Certainly feel free to sort of, I guess with permission of His Honour, rephrase my question if I haven't quite asked the question even properly.

MR. WRIGHT: Well, thank you for the question. I think that systemic racism is something that we are beginning to understand exists. And I say that because in recent history as various portions of our society, institutions in our society, have been challenged with systemic racism or the presence of systemic racism in their midst there have been some notable leaders in Canada who have resisted acknowledging the existence of systemic racism. There have been chiefs of police. There have been leaders in field of Correction and others.

And so I guess I'd like to start by saying systemic racism is real and it exists. Systemic racism, sometimes we speak about institutional racism or structural racism is a term that refers to a form of racism that's embedded in our society, and it's embedded in our society in our laws, in our policies, in our regulations, in the constructions and the bandaids of our institutions and that that's present in all sectors. It's present in criminal justice, employment, housing, healthcare, education, politics and electoral representation.

People might think it doesn't exist in some areas like oh, maybe the fisheries. Well, actually it does exist in fisheries. People of African descent historically had tremendous involvement in fishing as a part of their subsistence economy and now it's hard to find a person of African descent who is in the fisheries.

In land, well, actually the way Black people were given access to be resident on land was systemic racism in terms of many not being given actual land grants but given occupation permits and we hear about it in the news today that makes it difficult for them to take any economic benefit out of that land or even to pass it on to their descendants.

So systemic racism is that; the racism that's embedded in our institutions. And we should not be surprised that systemic racism exists because if Canada is a colonial state founded by, you know, Europeans who came to this land, then we need to recognize that the Europeans who came here that racism was the original sin that they brought, right. So Canada was founded on, in part, the attempted genocide of First Nations and the enslavement and, at the very least, the exploitation of people of African descent.

(10:40)

And so our initial practices in policing, in health, in education, in all of these areas marginalized these populations and we are continuing to live the consequences of that systemic racism today. So that even if we woke up tomorrow and there was not a single person who harboured a single feeling of ill-will towards people of other races we would continue to live the consequences of systemic racism in all of these areas because it's embedded in the structures. So that's systemic racism.

If we want to think about how that has existed in healthcare, for example, we can talk about how Black communities are not located in close proximity to healthcare service delivery. We can talk about the under-representation of Black people in the healthcare profession because of the discrimination in education.

We can talk about the fact that health education is woefully devoid of any kind of powerful education about the healthcare needs of people of African descent.

We can talk about the fact that in this era of evidence-based practice if there has been an active absence of investigation of the healthcare needs of people of African descent then we have no evidence on which to base our healthcare practices to people of African descent. And so, in fact, I

would have to say that this is one of the reasons why the African Nova Scotian Mental Health and Addiction Initiative was dropped. Because one of the leaders, one of the major leaders in mental health said, Well, that's not evidence-based so let's just drop it.

So this is, again, systemic racism. The absence of the things needed to make the case for our needs. And Ms. Davis-Murdoch has been a leader in trying to get the infrastructure in place just to do good research in health of African Nova Scotians. So we see an absence of personnel, an absence of knowledge, an absence of proximity and an absence of the structure actually pay any amount of attention to the mental health needs of people of African descent.

We see this similarly in the lack of family services. Again, there are in the Province of Nova Scotia some family resource centres that are dedicated to people of African descent, most notably in Halifax and Digby, but again, that sector is woefully devoid of resources and personnel to meet the needs of African descent.

The intimate partner violence community, again, we are not well serving the needs of women. And not to suggest that women can only be victims of intimate partner violence and only men

can be perpetrators, but just to be simplistic, we are poorly serving the female victims of domestic violence. And if we are poorly serving female victims of intimate partner violence, we have not even begun to understand and unpack the Gordian knot that is the experience of Black male perpetrators of domestic violence and the history of systemic racist violence that Black men are subjected to and how that affects their mental health and how it manifests in the violence that they perpetrate.

Our current models, the Duluth Model for understanding domestic violence does not begin to touch and explain Black male domestic violence perpetration. So systemic racism affects us from top to bottom in these sectors.

Q. And, Mr. Wright, at one point we are going to get into the perspective of Black males within that system and we'll certainly go back to that because it's a very ... it's an excellent point and it's something I wish to explore further this morning as we move along.

So with that, page 1 of the report, it indicates, there's a passage there that says, about the fourth paragraph down, it says: "Inability to access informed and culturally specific health resources and culturally competent care is a recurring reality."

That is put right into the report, which has been marked as an exhibit today, Exhibit 347. The Panel has certainly touched on that as we've gone along this morning. I guess my question is twofold again is how much of a recurring reality is this and could you please sort of explain that important passage in the report.

I don't know if there's someone on the panel that wishes to sort of take the initiative on that question.

MS. DAVIS-MURDOCH: Cynthia, might you be able to talk about the recurring things that you have seen at the sort of, I'm going to say coalface, you know, where you are and what you've seen through your career about this recurring reality? Would you mind sharing that with us?

MS. JORDAN: Sorry, just had to make myself ... So this is ... sorry, what paragraph is that, paragraph number 4?

Q. So, yes, it would be the fourth paragraph down.

MS. JORDAN: Mm-hmm.

Q. It ...

MS. JORDAN: "It's recognized that systemic racism impacts all aspects of service delivery in Nova Scotia as highlighted."

Q. Sorry, it's the fifth paragraph, my mistake.

MS. JORDAN: Okay. Sorry.

Q. It starts with: "Inability to access informed and culturally specific health resources and culturally competent care is a recurring reality."

So I guess the question there is how much of a recurring reality is it and ...

MS. JORDAN: Yes.

Q. ... if you could explain that passage.

MS. JORDAN: Mm-hmm, absolutely. So, yes, it is a recurring reality. It's a recurring reality when folks actually try to access services within the current systems that exist. So, you know, folks oftentimes will experience microaggressions. I'll give you a specific example.

When folks bring racism say, for instance, to the forefront as part of their issues that they're bringing to a clinician. When those incidents aren't validated oftentimes what you hear sort on the back end is is that folks are playing the race card. That's often a word that we hear that's often thrown around which is impactful to the individual folks.

Basically, they're met with judgments versus dealing the feelings or the emotions or the actual experience that the person is bringing forward. So oftentimes one's own judgment

when they don't come with a cultural lens of providing services, oftentimes the needs of the individuals are not being met within sessions and actually it continues to cause further harm.

And that happens on a regular basis. It happens ... so when folks ask then for a cultural relevant individual, say, for instance, if there is a Black clinician available for services that's often viewed as something very negative. Like why are they looking for a clinician who is of African Nova Scotian or African descent, you know, for a treatment.

So when we talk about the forms of discrimination that we experience within health systems that is discriminatory within itself in terms of people's interactions with folks from the healthcare system who are not culturally competent.

(10:50)

Q. Okay, thank you.

In the report it indicates at various points and I may be paraphrasing a little bit, but in the report it indicates that there is aspects of mistrust within the African Nova Scotian communities as it relates to the Nova Scotia healthcare system and the system that delivers the model of intimate partner violence or family intervention services.

I wonder if you can give us an idea or an understanding of

what this mistrust is, kind of where does it originate, and how does it play out?

MS. JORDAN: Yeah. Historically there has been a mistrust and it's something that we learn as a young person. If we go back historically there's the Tuskagee Experiment that happened within the United States with Black men, particularly in terms of syphilis.

There's other examples within the United States around healthcare system, you know, experimenting with, you know, vaginal surgeries for Black women within the New York area back in, I believe, it was the 1940s/'50s if I'm not mistaken. I don't have that information here with me.

But there's been a general mistrust even when it comes to dental care. Oftentimes, you know, historically there was certain anaesthesia or anaesthetics that were not made available to Black people that were made available to White people.

So these are historical experiments that happened in learning well, what are the effects of syphilis in Black men if they're not treated. So there was the idea that they were telling the individuals that they were receiving say, for instance, the antibiotic but they were actually given placebo in those particular cases. And for Black women in terms of, you

know, surgeries that were done, experimental surgeries in terms of fistula repairs.

So there has been an underlying mistrust within systems, and that carries forth in terms of generationally. When folks go to healthcare services and they don't receive, you know, adequate care then we're less likely to actually access those services.

You know, in terms of, you know, the Guysborough area oftentimes what has happened is is that folks will, within the Black community in general, they will not actually seek services early on. Oftentimes they seek services later in the duration of an illness. So did that answer your question?

Q. It certainly did, yes.

MS. JORDAN: Yeah. It's historically built into our ... if I could say, we learn from an early age, and sometimes it's not something that's necessarily communicated verbally, it's communicated through behaviours.

MS. MACLEAN: If I could add slightly to Cynthia's comments. When we look at the impacts of intimate partner violence, particularly on Black women, one of the cultural norms that we learn very early is that the Black men may not be treated fairly within the criminal justice system so we see a

disproportionate number of Black men being incarcerated and, as Black women, we do not want to be complicit in having our Black men be sent to jail as part of the history of what we see in terms of how Black men and Black women are treated within the criminal justice system.

But the others, that there's these cultural nuances and cultural norms is that we can't take our business outside the home. That, you know, to talk about it is actually, you know, threatening to the community, as it sees us as fractured, it sees as our vulnerabilities.

And that historically servicing agencies like Family Services associations, like the Nova Scotia Health Authority and the IWK do not always have people who have a lens that understand who we are and our cultural practices and may already see us with deficits as we walk in and then these deficits get layered and amplified. So then, you know, I've heard in my practice that people just ... you know, they see us walking in and they already think that, you know, well, you know, that our parenting isn't good enough or that, you know, what do you expect, you know, Black men are raging all the time or Black women are loud and boisterous.

So these stereotypical images and how systemic racism plays

within institutions that are supposed to deliver these services don't always have cultural competency built into them and it gets even more unique and more nuanced when you're in rural Nova Scotia. To have, you know, someone who is employed by Family Services Association, who feels comfortable in asking clearly what does that mean to be a Black woman or a Black man who's experiencing, you know, domestic violence. Because there are some cultural pieces to that that really speak to some of own histories; it speaks to some of the fragilities within the community as well as the resiliencies in the community.

And as I said earlier, there are pieces within the community that people historically pivot to for those supports, like the church or elders in the community, and it gets even more intimate and more challenging in rural Black communities where relationships are very intimate and closely intertwined.

Q. So you pre-empted the very next question, and I guess before I request His Honour perhaps take a morning break, is that if you could sort of explain to us is there a unique aspect of that when you look at African Nova Scotians in a rural community versus an urban?

MS. MACLEAN: Absolutely. There's several unique aspects to that. One, of course, is like we spoke to around access to

resources that, you know, in Halifax we have more resources because we're an urban centre versus a rural community where people who, even in the African Nova Scotian community, and if you're a professional in those communities you already know the professionals in the White community and so there's some double jeopardy for you to disclose that, you know, you're experiencing domestic violence. Well, you know, the White community may not feel safe or that you're trying to, quote-unquote, save face so you don't look as if you're a vulnerable person.

There's all these nuances because of we are a people who are relational and our relationships build our capacity and our resiliencies but they also make us very vulnerable. And what I mean by that is quite simply the smaller the community the more intimate the community, the more the people can kind of pivot to say that, you know, let that happen in that family. If Lana or someone needs help they'll come and use the informal social supports that they need.

But most of those supports that historically were in the community are no longer in rural communities as we know them because of the out migration of the resources and people. So there's those small nuances to access to resources that are culturally specific and historical within those communities to

access, but also the internalized racism that people may experience if they want to access those supports in smaller intimate communities in rural Nova Scotia.

Because you know the executive director of the transition house because I'm the social worker in the community and if the violence is happening to me, I don't feel safe to actually access that because I maybe have to work through my own shame issues and my own issues around disclosure of what that looks like and the impacts it may have on my family and my community.

Black women don't ... and I would say the conventional wisdom around White feminist ideology which is a lot of how transition houses and family services are built upon, don't take into consideration what I call a womanist or a Black feminist lens on how they deliver services either.

MS. JORDAN: And I'll just add to that if I may. From working within the system, being of African Nova Scotian descent, oftentimes when we advocate for culturally responsive services we often become a target as being resilient or being, you know, stigmatized as, you know, angry or resistant or resilient to the way in which businesses often run within the system. So that comes with its consequences as well.

So the lack of knowledge and information around anti-

oppressive and anti-racism behaviours oftentimes, those particular incidents are not viewed as anti-oppressive when they are actually anti-oppressive.

MR. RUSSELL: Your Honour, that's sort of a ... I'm thinking of the Panel and I guess everyone in the room, sort of a natural starting point, I guess, or ending point.

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

Folks, we generally take a morning break and take an afternoon break, and if you're still here in the afternoon we'll have one as well, but for now I think we'll take a break. It's almost 11 o'clock and perhaps 15 minutes or thereabouts should be sufficient for people to maybe just stretch a little bit and have some refreshment, all right. So we'll return about 11:15 or thereabouts. Thank you.

COURT RECESSED (11:00 hrs.)

COURT RESUMED (11:17 hrs.)

THE COURT: Mr. Russell?

MR. RUSSELL: Thank you, Your Honour. Just before we move to the next portion, a comment was made very early on that said, and it's in the report, "We rarely see ourselves reflected in a healthcare context." I certainly didn't want to gloss over that and I would ask, perhaps, the Panel, if someone could explain to

us what that is, and why is it important in 2021, and what is needed? And the line is, "We rarely see ourselves reflected in a healthcare context."

MS. DAVIS-MURDOCH: So I think we probably all could speak to that. I will start by saying that what I would mean by that would be that we do not see ourselves reflected in the, you know, even in visuals of healthcare programs. It's beginning to change, but it has been my experience that if there is a new program, if there is a new, even a healthcare message about, you know, in the early days of the pandemic, for example, the Health Association of African Canadians reached out, talked to government, talked to public health about the fact that we were not being reflected in the messaging. We weren't seeing ourselves in the advertisements, public service announcements. There was no wording, nor pictures, that would have reflected us to have, you know, that message sent to us about how important we were to the whole piece.

(11:20)

When you go to a healthcare institution, you know, there are too few of us represented in the institution as providers. It's not to say that there are not providers, of course there are, but there are too few; there are too few in key areas.

There are too few, you know, when you're looking for, for example, even a referral or, you know, you're in need of psychiatric care, there are too few of us who are psychiatrists. There are too few of us who are family physicians. There are too few of us who would be in primary healthcare settings among primary healthcare teams. So we don't see ourselves whether it is in the pictures, in the wording, in the messaging that government sends out, as is the work of the government. The work of government is policy, to provide information to people, to provide health services that meet the needs of people. Where are we? You know, think about even dementia care. The Health Association of African Canadians has forged, and continues to build, a relationship with the Alzheimer's Society of Nova Scotia, and I'm sure they would not mind me saying that in the early days of that relationship was the understanding that we did not see ourselves reflected in the services that they provide, in the language that they use, in the ways in which we, as a people, would see ourselves in need of dementia services when we know, anecdotally, that we may well be disproportionately affected by dementia. And I say, "anecdotally" because one of the main concerns and areas of advocacy for the Health Association of African Canadians has

been to have health data which has race, ethnicity, language identifiers so that we might know our health status, so that we might know the level of utility or utilization that we have in the health system. How many of us are in programs? How many of us are being served with new ideas? And when I say "new ideas", new proposals from the healthcare system. How many of us see ourselves there?

So there's a dearth of reflection administratively, clinically, in health messaging, in advertisements, in health research, a lack of prioritization when we, in fact, are a marginalized population, or marginalized populations, for whom, you know, the underservice disproportionately affects us.

One of the other areas, if I could just add, which is of some concern - a lot of concern, actually, is the area within the prison population. We are disproportionately, you know, evident in the prison population; yet, I cannot identify culturally-specific programming that helps our people behind bars, and were recently, in fact, talking specifically to people in the prison setting, and with their permission and with their support, a few inmates themselves who described how they were not receiving service that had anything to do with them. They weren't comfortable with it. They couldn't relate to it and

they were, you know, extremely underserved and very frustrated, and it was heartbreaking to not be able to know of a time or be able to point to a point in time, you know, when that was going to change. I can only say that we would continue to be advocates for service.

So I think I've given you many examples of where that lack of seeing ourselves reflected exists, and I invite my colleagues to add to that.

Q. Okay. If there isn't anything else from the Panel on that, I would move to the next question.

Page 6 of the report, at the bottom of the first paragraph, it references, it says: "The Black Learners Advisory Committee Report on Education, filed in 1995 with the Department of Education, spoke to disparities among African Nova Scotians and addressed recommendations to address systemic inequalities for Black learners."

That applies, obviously, in an education context. My question is, has there been any sort of study similar to that within Nova Scotia as it relates to what we're primarily sort of speaking about today which is access, mental health services, health services, family intervention services? Has there been sort of a level of an advisory committee as it relates to those

areas within the province; and, if not, is there any benefit to having one? Sorry for the long-winded question.

MS. MACLEAN: To my knowledge, there has not been anything formalized. It has always been on the side of people of interest, like the Decade for People of African Canadians or Nova Scotians. It's been work that people have championed off the side of their desks trying to leverage that same kind of opportunity that the Department of Education did with the BLAC report to pivot something to health and to community services.

So, to answer your question, to my knowledge, there has not been such a targeted approach to give us those kinds of outcomes and a path and a direction forward, with the exception of the small pieces that were named within the Together We Can mental health strategy.

Q. So the question ... Oh, sorry, go ahead. I believe ... was it Mr. Wright?

MR. WRIGHT: I just wonder if Ms. Davis-Murdoch might speak to the African Nova Scotian Health Strategy which is a much more modest approach than the Black Learners Advisory and what resulted from it.

MS. DAVIS-MURDOCH: Well, thank you, Mr. Wright. Let me just say that the African Nova Scotian Health Strategy is the

property of Nova Scotia Health, okay?

MR. WRIGHT: Yeah.

MS. DAVIS-MURDOCH: It is not the property of the Health Association of African Canadians.

MR. WRIGHT: Exactly.

MS. DAVIS-MURDOCH: We, as an organization, certainly helped to initiate ... in fact, it was initiated at one of our collaborative sessions with government where we have lots of those, in which someone identified the need for a strategy many, many years ago. And, indeed, you know, continuing to knock at that door, what happened was that there was a strategy committee put in place. The representatives, including myself from the Health Association of African Canadians, were on that committee, as were others, as were others. And we worked and met, and worked and met, and worked and met for years. I'm trying to think. It might have gone back to and, you know, I took an oath to say everything that I knew absolutely, so I'm going to say I'm not a hundred percent sure that it was 2016, but it was pretty close to that year when we began.

(11:30)

The African Nova Scotian Health Strategy has yet to be released publicly. Recommendations were numerous in that

report. Professor Ingrid Waldron was the author of the report, though the recommendations certainly came from people across this province. And, certainly, even specifically, portions of recommendations came from the Health Association of African Canadians. We presented the report and recommendations to Nova Scotia Health and that was before the last election. A new government is in place, in fairness, not that long but, for all of those years, that strategy has sat with recommendations that, you know, certainly were numerous, but could have been responded to, or at least responded to in part, as government often does, or Nova Scotia Health could do. You know, we accept these recommendations. We refer to or we defer on the others and so on and so forth. None of that has happened to date.

Q. Could you indicate when that work took place? I'm just trying to put it in context of when it took place. And then there's now this delay in the report that supposedly has excellent recommendations that, at the end of the day, there's a need to implement and act upon those. Can you tell us? I might have missed it but when was that work done?

MS. DAVIS-MURDOCH: I'm going to say, approximately, okay? I'm going to say approximately between 2016 and completed certainly by 2020.

Q. Okay.

MS. DAVIS-MURDOCH: And if not before then, okay, because the recommendations had to be in before the writing of the report took place, as you can imagine. So it has been in place, completed, for probably three years, if not more.

Q. And was your Association provided with any sort of understanding or explanation as to why the report is yet to be sort of released?

MS. DAVIS-MURDOCH: Well, with the previous government, there was certainly commitment to undertake the release of that. Senior officials from Nova Scotia Health recognized that it was a long process and that they wanted to be responsive. With the change in government, I'm sure that, you know, probably the same response is there, but with the new government, we have seen no release of the strategy. So I'm sure that perhaps they want to look at what recommendations they feel that they would like to implement. Perhaps they want to suggest different directions for others, I could not say, but where we are is that it is not in the public domain.

Q. Okay.

THE COURT: Excuse me. Do you know that the report has a title? Have you been advised as to what the title of the

report that has not been released is?

MS. DAVIS-MURDOCH: I'm not sure of the working title now but, suffice it to say, it is well understood as the African Nova Scotian Health Strategy.

THE COURT: Okay.

MS. DAVIS-MURDOCH: That is the language that everybody refers to and would understand.

THE COURT: And I take it that you've never seen a copy of it.

MS. DAVIS-MURDOCH: Well, as part of the Advisory Committee we, in fact, provided the substance, if you like, of the report and we're there as part of the presentation to Nova Scotia Health of the report and recommendations, and that was under the previous government. So, to that extent, I have seen it, but it is not ours to release, Your Honour, as you would understand.

THE COURT: Oh no, I appreciate it, but I take it that there's recommendations that relate to, for instance, mental health?

MS. DAVIS-MURDOCH: Yes. High level recommendations around mental health. And you can imagine that I don't want to be floating that or even referencing it very much more because it would be inappropriate, I think, to do so. But many

holistically looking at services, looking at needs within mental health, within physical health, within even support of advocates in the province who are pushing forward improved healthcare for people of African ancestry. At the highest level, those things are included, Your Honour.

THE COURT: I'm going to interject again, but I'm going to collect my thoughts before I do, so I'm going to let Mr. Russell continue here. Thank you.

EXHIBIT P-000348 - "TOGETHER WE CAN" - ORIGINAL REPORT

MR. RUSSELL: Thank you, Your Honour.

Similar to that area, and I know His Honour had asked questions earlier about Together We Can, and we do have that as an Exhibit 348. Of I may, I'm going to reference various portions in the original report which I understand was 2012. It's Exhibit 348. Just for context, I'm going to put portions of that report to the Panel and then I propose to have a series of questions.

Together We Can, I guess starting on page 6 of that report from 2012, under Guiding Principles, page 6, the second guiding principle, and I'm certain the Panel is well familiar with this report, it says: "Offer health equity. Opportunity for health for all regardless of age, gender, ethnicity, religion, sexual

orientation, or socioeconomic status."

So that's listed under a Guiding Principle. Page 22 of the report, it refers under Aboriginal and Diverse Communities, it reads:

> Mental illness and addictions cross all boundaries in our society including gender, income, ethnicity, race, geographical location, sexual orientation, and language. These characteristics must be taken into consideration when looking at the factors that influence mental health and addictions and when developing programs and delivering care that meet the needs of all Nova Scotians.

And then, in particular, under Diverse Communities, it says:

> Many members who are members of specific communities have not been served sufficiently by the mental health and addictions care systems for generations. Based on what the Advisory Committee learned, diverse populations in Nova Scotia

that require specific attention when it comes to mental health and addictions care include:

- First Nations and Aboriginal citizens;
- African Nova Scotians;
- Acadian/Francophone Nova Scotians;
- New immigrants to Nova Scotia; and
- Lesbian, Gay, Bisexual, Transgender, Intersects, (LGBTI, as it then was) communities.

And then it references an action plan. I promise there's questions at the end of this. And the action plan is:

Set up diversity implementation groups with representatives from new immigrant, Acadian/Francophone, African Nova Scotian.

And it lists other communities. And then, finally, at page 25 of the report it says under Recruitment, it identifies:

First Nations citizens and people from other diverse communities would like to have diversity better represented among members of mental health and addictions care teams. This is an ongoing challenge.

And it lists the second action, then it says:

> Expose young people from diverse populations to mental health and addictions needs in their communities and encourage them to explore the career opportunities in these fields.

Looking at that report, and they're the various passages, I believe, your report had made reference to. This report, in 2022, would be released approximately a decade ago. So my first question is, and it refers to this being a five-year plan, why a five-year plan, I guess, and is there value in this being implemented beyond a five-year plan, based on your level of expertise?

MS. MACLEAN: Well, as someone who sat on that particular Board, I'll take accountability for why it was a five-year plan. My memory and recollection was, at the time, those senior leadership within the Department of Health and Wellness wanted to have some specific outcomes and actions and have the Department of Health and Wellness at the time be accountable for those outcomes. And we also recognized around the table, those of us who sat on that committee, the urgency, because we were seeing such major significant gaps in the service delivery to

those particular targeted communities. Some of those communities had infrastructure already in place that could leverage certain pieces, like our First Nations mental health and addictions communities. Other communities did not have those same levels of infrastructure.

(11:40)

So the reason we put five years, to the best of my knowledge, was a level of accountability to those communities that were identified and to have action by government to ensure that there has been implementation and some meaningful dialogue with those communities.

To my knowledge, the advisory committee piece that was spoken to, I believe, on page 24 of the report, there was an attempt by those of us who sat at that table to continue the work as part of coaching and getting some community buy-in. Again, I believe, when there was a change within the government at the time, organizationally, all those pieces and all those initiatives - particularly, those recommendations - just got lost in the shuffle. And those of us who were volunteering our time to sit around that advisory committee at the time just got moved into our regular jobs. It was, again, work off the side of most of our desks. At that time, people like Patti Melanson

was working with homelessness, and myself and a few other folks. So the initiative to do the work was there. The support to do the work was not formalized in a way that allowed that work to be championed and to be continued within those diverse communities.

So, yes, there was a hope and a willingness at the time, and I do believe, when government systems change, things get lost, and that committee got lost.

Q. I guess that's why I ... Mr. Wright, go ahead, sorry. I think you were going to say something.

MR. WRIGHT: Well, I would just like to draw the contrast. So we had the Black Learners' Advisory Committee Report and, as a result of that, which was, again, created by community demand, we've now, 40 years later, we see tremendous infrastructure in education designed to address the needs of people of African descent. We have data in education, so we know how Black students are doing. We have a provincial infrastructure in African Canadian Services Division within the Department of Education. We have school board administrators, race relations coordinators, and we have student support worker programs where every school has access to, and a person of African descent who is there to support Black students. We have

recruitment of Black educators. We have the Delmore Buddy Daye Learning Institute and the curriculum development. We have graduate level programs for Black educators. So we have a significant number of vice-principals, principals, and now even guidance counsellors who are people of African descent. So we saw that the system of education, although there's much work to be done there, the demands and the needs of the African Nova Scotian community was translated into structural systemic services to meet the needs of people of African descent.

Unfortunately, and I'll be plain, the systems of health have not done well to respond systematically to the similar needs despite the fact that Together We Can identified it. And Together We Can, again, was not a specific inquiry into the needs of people of African descent, but certainly evidenced the needs of people of African descent. And Ms. Davis-Murdoch shared with you that the African Nova Scotian Health Strategy has, in my words, languished. There has been a single individual hired within the Department of Health or the Health Authority. I'm not quite sure where that position is located.

MS. DAVIS-MURDOCH: The Health Authority.

MR. WRIGHT: Within the Health Authority - Nova Scotia Health - a single individual hired to shepherd that strategy.

So if you take/compare what has occurred in health to what the response was in education - Health being a department with a budget significantly higher than the Department of Education - we would see that the Department of Health's response to the needs of Black Nova Scotians has been paltry and nearly insignificant.

Q. Thank you. Consistent with sort of that line of questioning about ...

THE COURT: Mr. Russell, sorry.

MR. RUSSELL: Sorry. Yes, Your Honour.

THE COURT: Just let me ask a question. Mr. Wright, why do you think that is?

MR. WRIGHT: I'd reference our earlier discussion of the nature of systemic racism. There is systemic racism, top to bottom, in all of our systems, and that systemic racism will only give way through the concerted efforts of members of a community continuing to press. Education had its Black Learners Advisory Committee review and it was a - what would I call it - a provincial tragedy and demand that was sustained for the last 40 years. Health, and particularly mental health, has not had its Black Learners' Advisory Committee moment. And, as tragic as this fatality review has been, perhaps this will be that

moment for health and community service that delivers those programs to support families around domestic violence. Only time will tell whether or not this Commission, this Inquiry, serves that function, and only time will tell whether the government and the delivery systems of health and community service are responsive.

THE COURT: Thank you. Mr. Russell?

EXHIBIT P-000349 – "TOGETHER WE CAN" - PROGRESS UPDATE

MR. RUSSELL: Following up with that line of questioning as it relates to ... and I know we're talking about a previous government. This present government is just operational since the summer and just getting established but I want to ask you a few questions about the report that was released five years later. We have that marked as Exhibit 349 and, in particular, page 4 of that report. So the government of the day had released this supplemental progress report under Together We Can and, in particular, there are three paragraphs that I would like to, and I know you're very familiar with this, draw your attention to. It says, the first:

> Treatment for mental health and addictions isn't a 'one size fits all' approach. We know there is a lot more to learn about how

> we can best work with First Nations, African Nova Scotians, and other individuals whose cultural experience plays a role in both their illness and their recovery.

The second paragraph reads:

> We have worked with these communities to develop training and awareness to help clinicians work more effectively with First Nations people, African Nova Scotians, and with immigrants.

And then the last paragraph, it says:

> We have worked with Health Association of African Canadians to better train clinicians about the needs of African Nova Scotians. The Health Association of African Canadians has also organized two conferences in the past two years on the mental health and addictions needs of African Nova Scotians.

Later, we'll ask you about those two conferences, but for the purposes of this ... so this is the supplemental report. It is telling the public in this publicly-released document that they have worked with those communities, including African Nova

Scotians, and it's developed training and awareness. I believe the word "paltry" was used. How accurate, sort of, is this as it relates to the reality of what has happened in that period of time between 2012 and 2020? Are you able to comment on that?

MR. WRIGHT: I would say, to be plain, that Ms. MacLean and I have probably been two of those individuals most significantly involved in training initiatives around mental health in Nova Scotia as it relates to people of the African Nova Scotian community. And I think we've explained to you earlier that what is being referenced here is likely the African Nova Scotian Mental Health and Addiction initiative that she and I were both consultants on. They reference the conferences specifically. What they fail to say is that they disbanded the network and did not translate the curriculum that we developed into a platform so that it could continue to be informing mental health clinicians and practitioners in perpetuity.

(11:50)

So I would say that although those statements are accurate, they do not tell the full story of the lack of efforts that have been made to thoroughly ensure that the needs of people of African descent are understood comprehensively by practitioners in mental health and addictions.

Perhaps Ms. MacLean would want to further or confirm what I've said.

MS. MACLEAN: I would confirm what you've said, Mr. Wright. I think that was a snapshot at a particular time in the middle of the work and did not accurately reflect moving forward to 2021, moving into 2022, any meaningful investment.

Q. Okay. And just in there, they specifically reference - the government of the day that oversaw this work, said "significant progress". Would you say, at the time, there was significant progress, you indicated that it was disbanded, and since this 2016 up until 2021, have you seen significant progress? Would you agree with that?^

MS. MACLEAN: Actually, I've seen less progress and a slippage back to the ... less attention to culturally-specific needs in the mental health and addiction portfolios. It's not become a priority. It has become ... the focus within those portfolios has shifted around meeting particular outcomes that have very little to do with appropriate service delivery to the African Nova Scotian community, to members of the Indigenous community, and to the LGBTQ+ community. There has been no significant movement, to my knowledge, since that report/update came out in 2016.

Q. And I understand, Ms. Davis-Murdoch indicated that, more recently, there has been some collaboration with the Health Association of African Canadians. I'm curious to know, up until recently, how was the collaboration between where we left off in 2016 and where it was in the early days of 2021? How was the level of collaboration between this supplemental report and at that point?

MS. DAVIS-MURDOCH: I would say that there have always been individuals who were interested in reaching out to the Health Association of African Canadians to, you know, to talk to us or to ask us opinions about - very often, to ask us opinions about papers or work that's been going on.

When I was employed as a public servant with Department of Health and Wellness, for example, I sat on the Advisory Committee of the Dementia Strategy, okay? So I was involved then. That would've been 2014/'15, approximately, because I retired in 2015. There has been ... since then, certainly, I have personally received calls on behalf of ... they're asking me, on behalf of the Health Association of African Canadians, what my feelings were about how the system was supporting our populations, and had lengthy conversations with public servants from the Department of Health and Wellness about mental health.

And, in fact, I suppose, within the last, oh dear, the last several months, I applied, on behalf of HAAC, the Health Association, to funding looking at the needs of Black women. And, in that, specifically identified the need for a primary health care alternative or option for Black women.

I was also, and HAAC was as well, through me, instrumental in building the Nova Scotia ... or establishing the Nova Scotia Brotherhood Initiative which is a primary health care model, and they have been in existence, or put it this way, they have been established since 2015 and provide primary health care, including mental health care services. And so the latest request then was to have an option or a primary health care equivalent, I'm going to say "equivalent", for Black women called the Nova Scotia Sisterhood Initiative. We've been advocating for that since 2017. One of the partners we work with, as I've said, we work with everyone, has been the Dalhousie Medical School, and we have collaborations with them in which some of their medical students work with HAAC in-service learning so that they can get a sense of what we're doing, you know, be involved in it, and learn from that experience. And one of the students, quite a few years ago, wrote a paper about the need for a Nova Scotia Sisterhood

Initiative, and we have been advocating for that consistently.

So what happened as an outcome of our writing that proposal was, for the first time, our organization, the Health Association of African Canadians, received a significant grant compared to what we have received in the past, to support our proposal which was to build and establish the foundation for a primary health care model called the Nova Scotia Sisterhood Initiative and part of that was for mental health services specifically for Black women. And, foundationally, what we want to do is to kind of build some resources that will be in place for, you know, many years such as, you know, videos and virtual group therapy, in keeping with what Ms. MacLean has talked about, the need for virtual care so that it's accessible to people throughout the province.

So we have put forward those as the kinds of resources we want to work with Nova Scotia Health to establish so that when a fully-funded primary health care model called Nova Scotia Sisterhood Initiative is established and our undying hope is that that will be in the next fiscal.

So that gives you a sense of what that collaboration, what that outreach, what those connections have been. We are waiting to reap the benefits because, as my colleague, Mr. Wright,

pointed out, the need for Black health infrastructure is a resounding need and one that the Health Association of African Canadians have advocated for since its establishment. But, certainly, you know, one of the foundational pieces is primary healthcare, and so we need that, and we need those two primary healthcare models as part of that. And we need people at every level of the health system, including in administration.

And so one of the other things we advocated for, as part of our work around the African Nova Scotian Health Strategy that I referenced, was that there be an individual in the Nova Scotia Health infrastructure whose job it was to indeed advocate to inform the system about the needs of people of African ancestry. And that was an early recommendation of the Strategy so it was foundational to the rest of it, if you like, and that was agreed to. And so that person has been hired and she is in place.

So I think that that really is as transparent and, you know, that is as much as has really taken place between the Health Association of African Canadians and government over that time.

(12:00)

Q. Okay.

MS. MACLEAN: If I can, for a moment, just ...

Q. Sure.

MS. MACLEAN: I just want to just draw our attention to the fact that there was a child also involved in this particular matter - a fatality.

Q. Yes.

MS. MACLEAN: And one of the aspects that we have failed to draw our attention to is the mental health needs of children and adolescents who have been significantly impacted in terms of their mental health and wellness. And my company, which is Lana MacLean & Associates, has been contracted by the IWK to look at what a service delivery model would look like to develop an African Nova Scotian program specifically within the HRM jurisdiction. So that is a work-in-progress simply because we recognize, and we've been having a lot of attention to adult mental health, but there has to be some attention drawn to the impact, that the children have significantly suffered through this particular fatality and their own mental health issues. So I believe we need to have a broad-spectrum look at just at mental health issues. As I conceded earlier, it's, you know, from cradle, from maternal mental health, to senior mental health. And in between there is significant impacts around the mental health needs of adolescents in the African Nova Scotian

community that go unrecognized until those adolescents are in conflict with the law or until those adolescents are having significant addictions and mental health issues that could've been some early prevention-related work.

So I wanted to say, there is something afoot within the IWK Mental Health and Addictions program to look at the unique, specific needs of the African Nova Scotian community. It is a very jurisdictional-specific program that I think they're looking at building and we're in the process of trying to leverage that and, you know, and working with the senior leadership of the Mental Health and Addictions program at the IWK, both in terms of administration and in psychiatry. So there are small, gradual ways forward that there will be some hopefully systemic change.

Q. I wonder, Ms. MacLean - and, again, the goal here was to start broad and then, as we go, more specific - when we had a discussion in preparing for today; in particular, you made a reference to the community where the Desmond/Borden family, where this tragedy had happened, and you used an example. You gave us some insight about the children that went to school there. I guess if you could perhaps, for His Honour's benefit, explain what you became aware of as a result of this tragedy as

it relates to children and adolescents within the community where it happened.

MS. MACLEAN: Certainly. Just for a little piece of history and context; so, in Halifax, during 2016, there was a series of murders of young Black men in the North End, about six or seven, and what was happening in those vulnerable communities was that children were being sent home, suspended. Children were having reactive behaviours. Parents were not necessarily attending to the psychological wellness of their children. And so it led to, at one school in the metro Halifax area, several children being suspended. People were not recognizing that they are actually having a trauma response. And so HAAC ... I was hired at the time to do some work in the Metro area to help support the Department of Education, African Canadian Service Division, to offer some clinical supports because no trauma team activation was provided to those children as it would have been offered to white children at the time when there are like crises in the school system.

When the Desmond Fatality occurred, one of a colleague who is a teacher, knew about those particular services that were offered and recognized that the same pattern was happening to a lot of the young Black children who were just not affect-

managing well in their school in the Guysborough/Antigonish County where there was more suspensions, children were preoccupied, having a lot of trauma responses, a lot of anxiety. And the educators at that time were responding to their behaviour as being oppositional and not looking at it from a trauma-informed perspective. So children were being bussed out of their homes, driving past the crime scene that happened, being triggered on their way to school, and no one was attending to their mental health needs. And, hence, again, you know, being sent into other areas of the school for in-school suspension because you can't bus them back home.

So there was a tremendous amount of impacts happening that no one was taking notice of except for this one particular teacher who spent time with her class trying to just settle them and doing some emotional coaching with them. And what was pulling out was the impacts of the loss of the little girl in this matter, the impacts of hearing adults talk and not have answers. They were watching people in the community increase in their substance use that was occurring as a way of managing their own emotional crises, and this group of children in the Guysborough/Upper Big Tracadie and Lincolnville area were just left alone.

So one of the things that happened was that HAAC was contracted with the Department of Education, African Canadian Services Division at that time, to develop "Mental Health 101" literacy programs to different rural Black communities, specifically to be targeted at the Antigonish/Guysborough/Upper Big Tracadie/Sunnyville/Lincolnville communities.

We went back. We were there previous to this incident once and then we came back again when this incident happened and spent a fair amount of time helping parents learn how to recognize what was happening for themselves, emotionally and psychologically, but also what they were seeing in their children.

Q. And I guess sort of my question is, that's in response to a tragedy and we've learned a lot about mental health and addictions, about preventative. So if you're looking at children that are part of a community and the trauma that's inflicted on them - passing the crime scene going to school, seeing their behaviours - I guess, do we need a trauma for the government to sufficiently contract with those providers that can be preventative even before tragedies or without tragedies? I'm trying to articulate the question, but I think the Panel will certainly understand it.

MS. MACLEAN: Yes. My interpretation of the question is, the only time in which Black mental health gets attention is when there is a significant crisis, and when the community then has an outcry instead of looking at interventions and recognizing the intergenerational traumas that all African Nova Scotian communities have experienced in this province.

So when there's a crisis, then there is ... And, unfortunately, this money came from the Department of Education, the African Canadian Services Division, not from the Department of Health and Wellness and not from the IWK at the time. So, again, the attention to the unique needs of our communities speaks to the history of anti-Black racism and speaks to the impacts of how systemic racism is seen and not responded to in culturally-responsive ways, particularly to the African Nova Scotian youth and children and families.

Q. So I guess a logical question from that is, do we need to see, I guess, perhaps more of a commitment to resources aimed at prevention without waiting for a tragedy to happen or without waiting for an impact to be seen?

MS. MACLEAN: I'm a believer in concurrent treatment options. Yes, prevention, but also intervention and also treatment. So it's a three-pronged approach, I think, as a

clinician, so there has to be some intervention work. How do we do that? Most of that work and from best practices is around parenting. It's recreation and leisure interventions with African Nova Scotians or people of African descent. It's developing mental health literacy in communities which is the work that this particular project brought forth. And I keep coming back that we are constantly doing project-based work, and to go back to what my colleague, Mr. Wright, said, it needs to be infrastructure work, and where there's some rootedness and there's some accountability instead of the community always hobbling together to respond to something which should be our human right, which is access to care. And that does not happen in a timely manner, particularly to African Nova Scotians in rural communities, let alone, you know, folks in the urban community can reach out and make a call to the 90 or 80 percent of Black clinicians that they know.

(12:10)

Q. And, I guess, before we move particularly to the Desmond and Borden families, there were aspects of your report and we talked earlier about, you'd advised the Court about sort of data, empirical sort of proof that sometimes people tend to require. But is it very much a reality ... and you set out in

your report; forgive me, I don't have the page number, but African Nova Scotian communities have fared - in terms of employment opportunities, financial advancement, education, and access to health - fairly poorly compared to other in the general population. Is that accurate?

MS. MACLEAN: Yes.

MR. WRIGHT: Yes.

Q. And, as well, it was indicated in your report that Nova Scotia has a history of not acknowledging properly the contributions of African Nova Scotians within this province. Is that an accurate statement as well?

MS. MACLEAN: Yes.

Q. My question, as a result of those is, in 2021, what is the impact of that, the over-representation of lack of employment opportunities, financial advancement, education, access to health care, coupled with that sort of lack of acknowledgment of contributions? What role does that play on someone's mental health even from an African Nova Scotian community? Even if they're not going, seeking help, what is the day-to-day impact on members of that community as a result of this, if any impact?

MR. WRIGHT: Well, if I could take that, I would just say

that we would expect that that would result in poor mental health, as evidenced by increasing sense of isolation and disconnection from community; depression. One of the things that we don't think about as a mental health thing, but out-migration. When African Nova Scotians leave Nova Scotia to go elsewhere for these opportunities, then they experience isolation, disruption from their cultural location. And we should also see that depression, anxiety, these sorts of mental health problems, manifest then in increased substance use, increased aggression. I often say that the mental health issues that are experienced by people of African descent are more often responded to by the criminal justice system than the mental health system. So if you have people who are experiencing depression, who are experiencing hopelessness, who are experiencing anger, who are experiencing increased uses of substances, you can imagine how that manifests in their interactions with each other within the home and within the community, and then that is then responded to by 911 calls, right? And we see this. I mean I am the pioneer of a thing we call "Impact of Race and Cultural Assessments" which is, you know, enhanced clinical presentence reports for people of African descent who are being sentenced by the criminal courts.

And those reports - both Ms. MacLean and Ms. Jordan are also authors of these reports. We are that first wave of clinicians who are developing this model. And, to a person, when we do these reports, we are uncovering the unmet sociocultural, socioeducational, social, psychological needs of Black folk who are being sentenced for crimes.

Q. So I would ask ... you had used a number of terms that we know were repeated by various health care providers that were involved in interacting, diagnosing, and treating Lionel Desmond, and they noted depression, anxiety, substance abuse, increased aggression in the context of throwing of objects or hitting of objects within the family home that was described as sort of traditionally out of character for him, and a recurring theme - a very recurring theme - was this concept of isolation. And that word has been used an awful lot during this Inquiry.

From your perspective, and you're somewhat obviously familiar with the facts as they were called during this Inquiry, are you surprised to see that at all?

MR. WRIGHT: Sadly and tragically, no.

Q. And why is that?

MR. WRIGHT: Well, I think we reference in our report the work of Professor Joy DeGruy-Leary. Professor Joy DeGruy-Leary,

in her PhD work, talked about this thing we call "post-traumatic slave syndrome", and post-traumatic slave syndrome is kind of a way of describing how Black folk have experienced this legacy of systemic racism that is embedded even in our epigenetics, you know, the multigenerational history of trauma that is compounded by the current experiences of systemic racism that we experience every day. And she says that this manifests in many ways. Principally, she talks about vacant esteem, right, which is really this, if you can think about it, this kind of suppressed capacity for feeling things. It's a numbing. It is a drawing into oneself which is, itself, kind of a self-isolating thing. One cannot feel one's emotions. One cannot express them to the people with whom you're in a relationship.

So she talks about vacant esteem and a propensity for aggression and violence. And we need to understand that when she speaks of this, she speaks of this not to suggest that Black people are inherently more aggressive or violent than white people, but what she's saying is that the history of trauma experienced by Black people that is paired with an inability to, and a lack of opportunity to have that addressed and treated results in this anger that is untreated, that then is triggered in ways that makes Black people more reactive to the triggers

that they experience in society. And then, of course, the other thing is the lack of access to treatment in healing resources.

Q. We've heard from Shonda Borden who had testified. She had explained that if Lionel Desmond was at work, she said he would come back ... he had been living with Shonda and Shanna in New Brunswick and he'd experienced incidents of racism at work and he would come home. They'd say that he'd be very sort of activated. He'd be upset about the dishwasher. He would ruminate on that and almost continue. Is that sort of perhaps, I don't want to be overly simplistic, but is that perhaps connected to what it is you're saying?

MR. WRIGHT: Certainly. And, again, I did not treat Mr. Desmond, so I wouldn't want to be overly simplifying, but I would say that those kinds of behaviours are consistent with the kinds of things I've described.

Q. Okay. In terms of the Desmond family, your report indicated that you learned or you've set out a bit of the history about the Desmond family in the community. I'm wondering if you could indicate that for the Court, what it is that you learned about the Desmond history, I guess, in the community?

MS. MACLEAN: Cynthia, you probably are best to speak to

that.

MS. JORDAN: So what is your question, more specifically, sorry? The history in terms of mental health, in terms of social determinants of health, or access to services?

Q. I guess if you could tell us a little bit about, historically, the Desmond family, and a little bit about them and how they came to their community; what you learned.

(12:20)

MS. JORDAN: Okay. So in terms of the Desmond family, the Desmond family would be a migration of the Loyalists, historically, to the Guysborough area. In terms of "historically", there are some Indigenous roots as well, in terms of the Aboriginal community, within the Desmond family. I, myself, yield from the community of Lincolnville as well. I know the family, however, I don't know specific individuals of the family, but I do know that the experience of those within the Guysborough/Lincolnville area have experienced racism within the education system. There was a documentary done in the '80s on the racism experience within the school system. In terms of segregated schools within the Lincolnville area, the last segregated school closed in the early '80s. The last segregated school to actually close within the province, or within Canada,

actually, was actually in Lincolnville.

There's been huge marginalization of the community. Income has definitely been an issue within the family. Access to employment. In terms of education and literacy, there have been huge disparities in terms of education for individuals. And physical environment, housing issues in terms of having adequate housing has been an issue within the community. The Desmond family, within itself, was a family home that housed multigenerational individuals.

In terms of healthy child development, definitely impacted by race and culture within the community in terms of racism. Health services virtually non-responsive in terms of culture and issues of race.

So when we look at communities such as Lincolnville, Upper Big Tracadie, and Sunnyville, there has been a lot of disparities in terms of all of the determinants of health when we look at those; when we look at the physical environments, when we look at, you know, health services, education, and so on and so forth.

So there are huge, huge issues in terms of culturally-appropriate services and education over the lifespan, over many, many, many generations within the community.

Q. And are you able to comment ... I asked specifically about the Desmond family, but are you able to comment about the Borden family as well and whether or not they would've experienced much of the same structures and ...

MS. JORDAN: Absolutely. Absolutely. Some of the same would be across all families within all communities within the rural area of Guysborough County and across Nova Scotia in general.

Q. Okay. I'd like to move into "Mental Health 101" that was raised earlier, and in terms of Health Association of African Canadians, their role in attending Guysborough pre and post-tragedy. So, I guess, to start is what is the "Mental Health 101", the Black experience workshop, and, (2) why was there a particular focus on rural communities?

MS. JORDAN: Well, there was a particular focus on rural communities due to lack of access in terms of culturally-relevant services in comparison to those within urban centres. We did focus on urban centres as well, but there was more of a focus in terms of the rural communities.

So when we take a look at "Mental Health 101" from a cultural lens, we were looking at the impacts of race. We used material from Dr. Joy DeGruy, as Robert had mentioned, and also

Dr. Williams, in terms of the impact of race on health and how that impacts. And the premise of the groups was to give a base understanding and some validation to folks that what they've been experiencing and how they've been feeling is important, and to give some literacy around those particular experiences.

Part of the focus of the "Mental Health 101" sessions as well focused on resources - what are available resources across the province - and, also, what are some healthy ways of coping with stress, with anxiety, with depression, and all the other things that impact mental health.

So that was, in essence, how the "Mental Health 101" sessions were structured, and very different from, you know, traditional kind of mental health that you would receive within a health authority. So there was a huge focus on race and how race impacts health.

Q. How often do these workshops take place? Is there sort of a structured ability to have these workshops or how frequent are they?

MS. JORDAN: Well, this was a specific project that was in collaboration with HAAC and with the Department of Education and it was a time-limited workshop. So we had, and maybe Sharon could speak specifically to this, but it was over a period of, I

believe, one year. The hope was that we could continue these workshops, however, it was a project; it wasn't something that was basically implemented as part of a service delivery program. So, in terms of projects, they have a start and they have an end date. So those resources were used; they were used effectively. Folks were asking for more. They were seeking more information. The responses in terms of the surveys, folks were feeling that it was meeting their needs, but they needed more - more services, more in-depth information - and folks were even seeking information around, you know, individual treatment in therapy and that sort of thing that would help them to do more long-term work around, you know, identifying emotions, having that emotional regulations literacy, and understanding on how they cope more effectively within the stressors that they experience.

Q. When did these workshops take place?

MS. JORDAN: They took place between 2017 and 2018. They may have trickled into 2019 a little bit, Lana, but I don't think. I think 2018 was the end. It was one year.

MS. MACLEAN: So there was two cycles of the programming. So the Department of Education, African Canadian Service Division, under their direction, they targeted the rural

communities noting that there was significant conversations happening with students - the Black student support workers, regional educators from the Black Educators' Association. They were all coming to the Department of Education saying, We need some information, some supports. Again, at that time, SchoolsPlus and all those other programs were not necessarily implemented in those particular communities as they were enriched and provided in the Halifax or HRM area.

So, at the time, the African Canadian Service Division asked HAAC to actually - Sharon, if I'm correct - to really focus on Digby/Yarmouth/Sydney/Amherst, anywhere outside of Metro, but particular attention down to the Antigonish/Guysborough/Sunnyville community. And that was pre-Desmond and we were there because folks were just trying to work through issues of stigma around mental health, showing people that there are Black mental health clinicians in the system; just developing rapport and relationship and giving some, what we would call "Mental Health 101" basic mental health literacy and how it shows up in Black lives.

And then the second rotation of that was those particular communities that asked for a second return with HAAC, to come back to those communities because a lot of folks couldn't make

it to the first session, heard about it, and wanted to come back. So, on average, we were running, and at least if my memory serves me correctly, about 30 to 40 participants in the Guysborough/Antigonish/Sunnyville/Tracadie group, total. So about 30 persons the first time around and about another 30 participants a second go round. There was a high level of interest. And, particularly after the Desmond Fatality, people were just really needing a place to process, and it became almost like a process group the second time we were down in that area because there was also other suicides that were happening in the community as well, that happened post the fatality.

(12:30)

Q. So, I take it, for this two-year period, there was a pretty active ability to deliver these workshops and there were benefits for members in the community. They were actually seeking for you to come back. And I took it that just prior to maybe 2019, it stopped. Is there any particular reason why it stopped?

MS. MACLEAN: I go back to saying everything is a project-based ...

MS. DAVIS-MURDOCH: Our continual ... our lived reality, as the Health Association or African Canadians, I mean you're

pushing me to say it, so we do not receive operational funding. All of our funding is project-based. We hope that that's going to change, right? We hope that's going to change. We advocate for it to change, but we have struggled for the last 21 years, based on our passion ... those people who are in leadership positions of HAAC, those members, such as Lana, such as Cynthia, who have a commitment to serving. And Robert was with us in those early days and, you know, he's saturated with all of the demands on his time. But the fact is that HAAC receives, you know, project funding; it's finite. We do it, we deliver it, we offer recommendations, and then we are not in a position to do anything else except have government hear the recommendations and act on them. And there are, you know, many, many grants out there. The federal government has numerous grants; the Province has grants. You do your best to navigate which one is most applicable and which one will give us the opportunity to work on areas of priority, you know, but our organization is largely unfunded as a structure. And so all of us, including the co-presidents, of which I am one and a founding member, are volunteers. We are volunteers because we are passionate about the health of our people and we need that infrastructure and we need to be supported to help the system improve the health

outcomes of our people. That's the reality.

MS. MACLEAN: And, Mr. Russell, just as a follow-up to Ms. Davis-Murdoch's comments, there's such a tremendous amount of passion to respond to the mental health needs of the community, that after the Desmond Fatality - because Shanna and Lionel were not part of the African United Baptist faith; they were of two different faith communities - the community had reached out to the African United Baptist Association, the AUBA, because there's a large cohort of that community that is connected to that faith and asked what could the church do? And the church sent down teams of laypastors and pastors to help the community process some of the race-based trauma they were experiencing, some of the complex grief they were experiencing. That's all volunteer when that really should've been serviced by the mental health infrastructure that should've been culturally responsive to the community.

So the community leveraged what they could at the time without the support of the Nova Scotia Health and without the IWK's support. That's all community work, unpaid work, because we care about the people who live in those communities.

Q. So this is a little leading, I guess, but is the take-away that the approach has been problematic in the sense that by

contracting this important work that has a start date and a stop date, there can be projects for sure, but when it's ... you've got a set allotment of funds for this project with a start and end date but, really, this issue of what we're discussing today about access to these two important areas of services for African Nova Scotians needs something that is not a model, that is contract work on an ad hoc kind of basis. Does it need something that is more fluid, that there's a structure of consistent sharing and part of an ongoing structure that's built? Am I getting that ...

MS. DAVIS-MURDOCH: Absolutely.

Q. Okay.

MS. DAVIS-MURDOCH: Yes.

THE COURT: Mr. Russell, it's about the time we would usually break for lunch. If it's an appropriate time to take a break then perhaps we'll do that at this time.

MR. RUSSELL: Yes, Your Honour.

THE COURT: All right, thank you then, Mr. Russell.

So this is the time we would normally break for lunch. We take approximately an hour for lunch, and so if we could have you back, say, at 1:30? All right, thank you very much, and so we'll adjourn for the lunch break. Thank you.

COURT RECESSED (12:35 hrs.)

COURT RESUMED (13:34 hrs.)

THE COURT: Mr. Russell?

MR. RUSSELL: Thank you, Your Honour. Welcome back, everyone.

I guess sort of picking up where we left off, earlier this morning you spoke about the need for increased African Nova Scotians within the healthcare system in terms of professionals, whether it be social workers, psychologists, psychiatrists, and that that's an identifiable need that is hopefully going to be working towards that end goal of having a more diverse representation within those various professions and deliver the expertise.

My question, I guess, would be unfortunately, I guess, right now in 2021, Nova Scotia is ... in those professions, whether it be social workers, psychologists, psychiatrists, ER physicians, it's predominantly non-African Nova Scotian and, obviously, as you've discussed, there's some limits with that.

What can be done in terms of an action item, I guess, to start ensuring that those individuals in those professions who are not from the African Nova Scotian population are delivering competent, culturally-appropriate healthcare to someone, say,

like Lionel Desmond or Shanna Desmond that would present themselves in the ER?

MS. DAVIS-MURDOCH: From a policy perspective, I think it would be, as I've said before, very important to have training built into the system. And I know that Mr. Wright referenced, you know, the importance of continuing to have conferences and mechanisms in which you can bring together people who are already in practice. But I think that there should also be built into the recruitment and the hiring ... you don't hire physicians, specifically, because they are independent professionals.

However, as part of their preparation to practice, medical school and so on, that understanding the importance of building cultural competence, being able to respond to understand ways of serving clients, that that be part of the system. So whether it's within schools of health professions where those professionals are independent or in the hiring of professionals, as is done through Nova Scotia Health, that that be a requirement at that point and that there be ongoing continuing medical education as part of being able to provide care to our populations. And I know others will have other ideas about that, as well.

MS. MACLEAN: Well, I do know that my college, my college is the Nova Scotia College of Social Workers, as of 2020 has implemented core competencies that all social work practitioners need to prove they have some level of competency in. So both in areas around indigeneity and Mi'kmaw history and knowledge of intergenerational traumas, issues around some level of competencies working within the African Nova Scotian community, and working with other diverse communities.

So I think there needs to be a targeted approach towards different colleges and different health professions to have some level of accountability on the ongoing required organizational practices and the ongoing education and health, like Ms. Davis-Murdoch said, health literacy and cultural competency literacy and be able to demonstrate that as a part of their license year.

How they demonstrate that would be, you know, certainly through some forms of continuing education modules, some opportunity to have a self-reflection team, every discipline team may want to have something slightly different. But in terms of what needs to happen with boots on the ground right now for practitioners is I think the Health Authority and the IWK, at least in this province, needs to acknowledge that anti-Black racism exists in healthcare and that they have to have an anti-

Black racism strategy and that that strategy is something ... and continuing education where you get CME credits for different disciplines, whether that's through their LMS online learning mechanism, or through conferences that we have put together in the past, which really speaks directly to the African Nova Scotian experience which is one of those three deliverables that Mr. Wright and Ms. Davis-Murdoch spoke to in the initial work that we put together from the Together We Can strategy.

(13:40)

Q. Ms. Jordan, I wonder if I could ask you, from a perspective of nurses within Nova Scotia, have there been any strides or where is Nova Scotia in terms of the training that's needed for nurses within Nova Scotia?

MS. JORDAN: Yes. So in terms of training just last week there was an announcement, or within the recent weeks, that they have increased a number of specific seats available to members of the African Nova Scotian and the Indigenous community, which is very encouraging.

There had been numbers of seats specifically available for members of the African Nova Scotian community and Indigenous community in the past. I know that those seats have kind of sort of faded away, but it's encouraging to see that the number

of seats available at the university level for those particular programs are available.

What I would also advocate for is information from the university perspective in terms of education around anti-Black racism, anti-racism in general, and anti-oppressive advocacy and how that would sort of, you know, pan out in terms of education. I know the School of Social Work in the Masters Program developed Senator Wanda Thomas Bernard at her time at the School of Social Work in terms of the anti-racism, anti-oppressive education that is available at the School of Social Work. So I would definitely like to see ... or see a need for such education within the nursing field, as well, for nurses that are going through the programs.

Also what I would like to see is some leveraging within the organization around the clinicians that they currently have within the system to utilize individuals to their fullest capacity to work within communities as well, the African Nova Scotian and the Indigenous community.

So, yeah, so those are just a few things that come to mind for me. I also see a need for support within the systems for those working within the system. Because even though we become employees of the system doesn't make us immune to racism and

discrimination within the workplace. So there is a need for support for individuals within the workplace that are experiencing racism and discrimination as well.

Q. Okay. In terms of specifically as it relates to Lionel Desmond, in your report you indicated the role of concurrent disorders and concurrent, coupled with trauma and the disorder. So in Lionel Desmond's case we know he had PTSD, depression, substance abuse, which is alcohol, childhood trauma, military trauma, and racial trauma. Those were some of the variables, I guess, that went into the complexity that was Lionel Desmond presenting in front of just about every type of healthcare provider there was, whether it would be nurses, psychiatrists, social workers, psychotherapists.

With that in mind, we had asked essentially every one of those service providers what sort of reflection or how did the fact that he was African Nova Scotian, how did that play into whether it was a diagnosis and the treatment and there didn't seem to be a lot of real reflection at the time under that reality.

So with that sort of basic background, I'd ask you a series of questions. I guess the first being, and you've touched on it a bit, but why is it important for the professional to

understand and see that someone like Lionel Desmond is African Nova Scotian? So that he presents to himself the hospital or in a session that's with a therapist or a psychologist, why is it important for them to sort of see that Lionel Desmond is African Nova Scotian and he's presenting with various mental health disorders and trauma?

MS. JORDAN: It's important because unless you acknowledge race as a determinant of health, you really don't get to the core of some of the issues that folks present with over the lifespan. When folks are presenting with mental health, particularly folks from the African Nova Scotian community, most are actually engaged when they enter into a service by someone who is white. And if the individual is met from the beginning with resistance around their experience, then the alignment of the therapeutic relationship doesn't develop.

And in terms of treatment services, it is essential in terms of having developed a therapeutic relationship with an individual in order to work with an individual around any issue, whether it be around race or trauma or depression/anxiety, et cetera. So it's important to acknowledge those factors as a contributing factor concurrently with the depression, anxiety, PTSD, et cetera.

Q. In terms of ...

MS. MACLEAN: If I can build on ...

Q. Sure.

MS. MACLEAN: Oh, sorry. If I can build on Ms. Jordan's reflections, we're taught to take a really good social history and a psychiatric history of individuals and to create what's called a cultural formulation about how do those things impact how you're going to look at treatment for individuals. And if a clinician who is Caucasian or outside the African Nova Scotian community doesn't do a cultural formulation about all those aspects, then you're actually missing a significant part of someone's history, particularly their social history.

So if you're taking a social history about, so how do the impacts of racism ... you know, how does that look like in your community, what was your experiences growing up with racism, how did you resolve those things, so looking at resiliency points but also clinically being able to have good conversations and make race present in the conversations about what are some of the resiliencies that you're able to bring forth, being someone who has survived or been able to move through some systemic racism issues, and building that into some treatment, but also what were some of the challenges. What are some of the

unresolved hurts? How do all these things manifest in our community and formulating that to say, Well, how does substance use present in the African Nova Scotian community? It presents differently in some communities than in others.

So how did you learn, or what does that tell you about, you know, like, for example, alcohol use? What we do know is that, you know, within the African Nova Scotian community, it's better to be seen sometimes with having an addiction than to be having a mental health issue. Right? There's some ways of having that be seen as a normative behaviour to coping with negative social ... psychosocial stressors than to consider it as having a depressive symptom or a depression. There's all these nuanced pieces.

It also means the client has certain cultural literacy or ways of explaining some other emotions and trauma. So when someone in the African Nova Scotian community a colloquialism is, My head is tight. I'm like feeling like my head's tight. That is a sign for us of anxiety and depression versus what the rote learning that we have taken on in our academic learning through the DSM-V there's nowhere in the DSM-V that says, Look for a condition that called "my head is tight".

So there's certain things that people of African descent

know are ways that are colloquially nuanced to make that person have understanding about what's happening in their lives, make understanding of the intergenerational traumas that their community or that they are taking on themselves. What does this mean to be a successful person in the military and to have that prestige? And what does that mean to the community? What does that mean to you as an individual around self-esteem and self-worth? It has lots of cultural nuances built into that.

And what does it mean then to be seen as somebody who is vulnerable in those particular locations? It's not just about the psychological impact it has on the person. But because people of African descent live and work and breathe in community, there's also community lenses on this particular way.

So if you're treating someone from the African Nova Scotian community, you're treating the individual, you're treating the family, and you're treating the community. It's a trifecta approach.

(13:50)

Q. I guess consistent with sort of that and the concept of mistrust that was imparted in the report, for example, Lionel Desmond had spent a considerable period of time in the Residential Stabilization Treatment Program in Ste. Anne's in

Quebec. And it was noted in the report that towards the end of his time there, they had reported that he had expressed a growing distrust and suspicion as to whether or not the service providers had his best interest in mind.

And it was sort of a little bit of a theme that would come up with Lionel Desmond that he would sort of express sort of a frustration or a little bit of questioning whether they had his best interest in mind. When those clinicians were asked about that, it was readily attributed to his diagnosis. It's his PTSD. It's a symptom of his PTSD. That's why he is growing suspicious.

As a service provider, from your perspective, is that maybe ... perhaps could it be overly simplistic in terms of the answer and explanation and would you normally explore it further? Could you sort of give me a sense of that?

MR. WRIGHT: Perhaps I could speak to that a little bit. When Ms. MacLean was speaking about, you know, taking a good social history of a client, this is not just something that you're hearing from three Black clinicians who happen to be here in Nova Scotia. The **Diagnostic and Statistical Manual of Mental Disorders** that's published regularly by the American Psychological Association has a thing called a Cultural

Formulation Inventory. So this idea of taking a good social history that it takes into account a person's cultural location and how they may be culturally interpreting their condition, this is something that is supposed to be standard in mental health service delivery today.

So, again, I don't like to wander into the area of what we sometimes call the "dueling experts", but what I would say is that if an expert provides a description or a discussion of a client's symptoms and challenges without having a detailed analysis of that person's cultural location and how that person's cultural location may be affecting how they seek service and how they interpret their problems, and how then the service provider needs to be responsive to those things in responding to their diagnosis, I'd say that the clinician is doing a disservice to the field to simply account for all of the difficulties that they're experiencing with their client as being indicative of the client's diagnosis.

Q. Thank you. In terms of in your report, you spoke about I think it was termed as "legacy of avoidance". I wonder if you could tell us a little bit about the legacy of avoidance within African Nova Scotian communities as it relates to; one, intimate partner violence intervention services, that dynamic,

and in terms of accessing mental health and health resources.

MS. MACLEAN: I can take a moment just to talk about the legacy of avoidance in terms of mental health. I just spoke to it just briefly. The issue of stigma and the impacts of stigma still linger within the African Nova Scotian community around, you know, someone being seen, quote/unquote, as crazy or not being able to manage their home or not being able to manage their lives. So with folks ... or don't want to be perceived as having not the resources that they need to make things work and be appropriate or to ... you know, to see themselves as having more vulnerabilities in a world that already sees them as having several deficits.

So in the African Nova Scotian community, sometimes you just, you know, you minimize or you may avoid getting and seeking help for those particular issues because you don't want to; one, you know, be considered to have an issue that you cannot control, or; two, that the issues of stigma and what will other people think of you and, more importantly, what do you think of yourself as someone who is maybe struggling with some of those mental health or addiction issues.

So to minimize or to avoid is an ability just to have things continue on, looking for psychosocial support in informal

ways versus formal ways to get some resolution. So that's how things historically may unfold within the African Nova Scotian community. So the significant impact of stigma is the primary one.

And the secondary is that we are a people who look at our resiliencies more than our vulnerabilities, that you are to struggle through things, you know, just to pray about those things, to, you know, go to other locations for strength versus to seek outside support, knowing that those outside support agencies, as we just spoke to, don't necessarily get who we are and, as Ms. Jordan said, causes additional harm. Because then it reinforces some of the things that you already know in terms of the legacy of systemic racism and anti-Black racism on the African Nova Scotian community.

Q. Is this generally what you refer to in the report as a multi-generational code?

MS. MACLEAN: Yeah. There's some of those code switchings or codes. Yes. They're not formalized in any means or manner. They require a complete nuanced kind of look. There are certain things like, you know, in certain cultures or certain criminogenic communities, you don't "rat people out". That's a code, an unsaid code but a known code. And within the African

Nova Scotian community, there's this intergenerational code that is, you know, your mental health is, you know, secondary to your physical health and, What is mental health?

Again, I would say our community is just starting to build mental health literacy and starting to have some understanding of those dynamics in their impact on our lives. It's something that we have been not necessarily paying attention to because there's competing priorities around survival issues, about housing, food, core economic ... Maslow's Hierarchy of Need. And down at the bottom is our health and mental health issues.

So, yeah, there's some of these intergenerational codes in which we actually have in our community that sometimes ... well, at times, places us at risk in terms of even talking about issues of domestic violence or intimate partner abuse because we don't want people to see our family or our community as being vulnerable to those particular psychosocial stressors.

MS. JORDAN: And in addition to that, some of these codes would also include like, We'll take care of ourselves. So, oftentimes, we go to the church. If we go to the public system for help, then we're going to be experiencing those stigmas and be looked at differently. And, you know, even sort of the code around calling the police, when you talk about, you know,

Shanna's sister who didn't contact the police, some of the codes within our community is is that, We'll handle that at a community level, because if we involve the police, then those systems cause further harms.

MR. WRIGHT: Yeah.

MS. JORDAN: They're not necessarily there to help us. They cause further harm is the general overview of what happens within the systems that are really built to protect and to help, oftentimes we see them as more harmful.

MS. MACLEAN: Yeah, you'll see Child Welfare becoming involved and children being removed from homes. That's a huge risk factor to call in the police if you're in a domestic situation. It re-traumatizes communities from that epigenetic perspective that Robert had spoken to around, you know, another state-sanctioned reinforcement or a state coming in to take our children away. So there's all these balancing multi-dimensional risk factors that we are kind of internally processing, but not recognizing what it looks like in its totality and its level of risk that we're operating under.

(14:00)

MR. WRIGHT: One thing that, if I could just add this, not to prolong, but as I was mentioning CCLISAR, I was in a

Panel on the weekend, we were discussing this issue. And a report was presented there which was the report of the project I had mentioned about looking into the issue of domestic violence in the Black community. And I'm just quoting from that report. "African Nova Scotian women are three times more likely to experience violence than non-racialized women; albeit, being a more vulnerable population, African Nova Scotian women have fewer supports available to them." And then this statement, "The reality for Black women is that when they call the police ... 'when they call the police, they are possibly calling in a death warrant for their partner'."

So, you know, with all of the news and all of the publicity around police shootings and violence by police against Black male bodies, especially, that is a dynamic that we need to understand when we think about the avoidance of seeking supports from the formal systems, particularly policing.

Q. And I guess, Mr. Wright, consistent with sort of the information you're providing us there, I guess I'll put four sets of sort of facts to you and perhaps if you can provide some perspective or insight.

We know that Shanna Desmond, on several occasions, that she did phone the RCMP when she said she had concerns for Lionel

Desmond's well-being. There was one particular call where he was in New Brunswick and he was threatening suicide. On the date of the tragedy, she had phoned Naomi Society. She was asking about the peace bond process for her and her daughter but she didn't disclose her identity, she didn't disclose her name and she didn't look for any assistance beyond that. It was very ... just asking a general question.

We also know that Shanna Desmond's, and it was mentioned earlier, sister Shonda ... she was provided with, what was very clear on its face, what would be sort of very threatening about Lionel Desmond and a firearm and he would have a firearm for Shanna Desmond. And she talked about sort of the approach that she would take and just trying to calm Lionel down and have a discussion with him.

And then, finally, Shanna Desmond indicated, through Lionel Desmond, to clinical care manager, Helen Boone, that Shanna wanted to access couple's counseling privately as opposed to going through Family Services Eastern Nova Scotia because she was worried that people would find out and know whether it was coworkers or other people.

So we have, I guess, Shanna Desmond does reach out to the RCMP on certain occasions, reluctant to give her name and

information to Naomi Society or ask anything further, prefer to go privately so it can't be identified I guess, as she's indicated, and a reluctance to sort of report the issue surrounding possibility of a threat, which is on behalf of her sister.

Can you offer any sort of perspective or commentary as to, from her standpoint or from the standpoint of an African Nova Scotian woman in that situation, and how her perception of things may be? I hope my question is okay and it makes sense but ...

MR. WRIGHT: Yes. I guess what I would say, and if you'll forgive some stupid analogies, and, again, not having been a person who treated any person in this family, but we all have these situations where we could seek services, but we have to overcome certain barriers in order to seek services.

So you go to the mall, you buy a bunch of things, you come home and there's an item that you don't want or doesn't fit you. You look at the item very seriously and you say, The hassle that's associated with returning this item, is it worth it? Right? We know the barriers. I'm going to call. They're going to look at me. They're going to wonder, Why did ... did I purchase it? Did I have a receipt? And sometimes we just say,

It's not worth it. Because I've anticipated all of the barriers.

So this is something that Black women, I think, and Black people seeking services have to consider every time they have a need. Where will I go? Look, if I call my church, they will understand me even though they may not have resources specific for me. But if I call 811, I'm going to talk to a nurse who's going to ask me a bunch of silly questions. If I call 211, will they really understand what I'm saying? If I go to my doctor, will they have an understanding? If I call the people at Naomi Society, will they have an answer for me? Will they violate my confidentiality? Will my community know? I mean there are just all of these barriers. So there are all of these barriers, these stressors.

And for people of African descent who are already carrying stress and trauma associated with contact with these agencies, we navigate the contact with those agencies very carefully to try to minimize the harm that they can do to us. And that puts us in this precarious dilemma then of then suffering from not seeking supports. And on the face of that, sometimes what we will do is we'll say, You see there's an example of a person not adequately seeking services when, instead, we should ask, Why is

a person from that background psychologically seeing so many barriers to accessing these services?

I don't know if that sufficiently answers your question.

Q. It definitely ... I believe it certainly does. And it leads to another question of in Shanna Desmond's situation and I know you only have parts. When it comes to family intervention services, what can the Province do to take the responsibility and use the effort to remove those barriers? Do you have any sort of insight as to how a government of a day can ... what can they do concretely to use direct efforts to remove those barriers? I know it's a broad question, probably a very broad answer, but I'm just trying to get a sense of ...

MS. JORDAN: No. And I think ... sorry. I think the short answer is culturally responsive care teams. And, you know, it's the same thing and it's like Lana alluded to in terms of child protection. You know, if Black people do not fit a certain script as what white people think we should fit, then the automatic is to remove the kids from the home, which could have been one of the looming things on the back burner for Shanna in terms of involving the police.

Because we know any time that there is domestic violence within the household, Child Protection gets involved. And,

Black women, we protect our kids at all cost. We try to protect our kids. Our families are very important to us. So anything that threatens that unit is seen as a service or a system that we don't want to have any sort of involvement with.

However, if I knew that I was going to see maybe Lana MacLean who would come to my house after I, you know, maybe called the police and dealt with an incident involving my partner, that Lana MacLean would understand from a cultural perspective in terms of what was going on and what the dynamics are as opposed to seeing things through a lens that is a Caucasian lens or a white lens that says, Your family should look like this and this is what you should do.

So as a way of breaking down some of those barriers and some of those judgements as having folks that look like us within those systems that we actually deal with, that actually can do an assessment and say, Well, you know what, I don't think this child necessarily needs to be removed. We need to try a different type of intervention that may not necessarily fit but is more culturally responsive to the family.

Q. Mr. Wright, I know you were about to speak there. I didn't ...

MR. WRIGHT: Well, I would just double down on what Ms.

Jordan said, culturally responsive care teams and access to Black experts in care; so even if there was a clinician who was not Lana MacLean in Lincolnville, for example, but that person had access to Lana MacLean, who was part of a team of provincial experts in culturally responsive care.

(14:10)

The reality is that if every Black mental health professional were deployed in these systems today, there wouldn't be enough of us. So the white clinicians and people who work in this system need to have access to us. And they need to build their credibility in relationship with their local Black community by showing that they have intimate connections with Black clinicians who work in this network, who regularly come through their area supporting them, providing workshops on Black mental health and the like, so that there is this generalized perception of all Black folk in Nova Scotia that my local mental health family supports and resources are informed and connected to the Black professionals who serve our communities whom we love, know, and trust.

Q. Consistent with that, it's an area that His Honour had explored a little bit or not a little bit, quite a bit with an expert, Dr. Peter Jaffe, an expert in domestic violence/intimate

partner violence. And he talked about a concept of a "warm transfer". And I'm sure, as clinicians, you're all familiar with a warm transfer of care.

He spoke about it in terms of the dynamic that is RCMP or police interaction with Shanna Desmond. So they respond to a situation that is Shanna Desmond isn't reporting that Lionel Desmond has committed any criminal act or even suggesting it. They're there because of concern she has for Lionel's well-being.

And the concept of doing a risk assessment and sort of gathering information which tells a full story which is a crisis that really has many layers and it's unfolding. And in comes this concept of warm transfer, which is the interaction with Shanna Desmond and an opportunity to engage services for the benefit of herself, her daughter, Lionel Desmond's mother who's there and, ultimately, Lionel Desmond. From a culturally competent lens, what does a warm transfer look like in that scenario?

MS. JORDAN: So is it okay if I take that? So in terms of, you know, culturally competent, warm transfer may look like someone who actually ... like say, for instance, in my practice if I have a client that I'm working with, I've built trust with

that individual and I'm passing the individual over to somebody else for a different level of service, then I may do an introduction ... I will do an introduction and I will have conversation before I do the transfer and say, This is what I know about this individual. This is how this individual is going to help you. This is what this individual knows about the circumstances that you are facing. So it's like a transfer of trust that the clinician doesn't have to then build and start over and work from.

So when you have a transfer of care, if it's a face-to-face and, you know, people of African descent are relational people. We are highly relational. You know, oftentimes, we're in conversations with individual. That's relationships. This community that we talk about, the African Nova Scotian community. That's relationship. That's Afrocentric. We exist within community.

So you have to have these communities within healthcare. You have to have them as they have been developed within the education system. Okay? That has been developed, where you have individuals on the ground that can do a transfer of care for a different level of service, a different level of treatment.

And that person that they're passing the care over to doesn't necessarily have to be of African Nova Scotian descent, but they, as Robert spoke about, they would have done the work within the community. They understand from a cultural lens what is important and how to work with people within the African Nova Scotian community.

And, therefore, when you have that warm transfer, you don't hit barriers as often. Not to say necessarily there won't be any challenges, but it strips some of those challenges away because the person automatically knows, I can trust this individual because they come recommended by Sharon, they come recommended by Robert, they come recommended by Lana, and those individuals who are well known within the community which they trust. And that's how warm transfers work. It's about having that face-to-face or today the Zoom, you know, one session where the individual is transferring the care.

Q. I guess ... Mr. Wright, I believe it was you ... I'd say approximately 15 years ago, you made a comment at a conference and said, We are not all the same. And how important is that recognition of "we are not all the same" when it is a police officer engaging with Shanna Desmond on a call that's not a criminal offence? It's just a call out of concern.

MR. WRIGHT: Well, I think that not only are we not all the same, you're belying my longevity in the field there, Mr. Russell. Not only are we not all the same, we do not all have the same experiences with different circumstances. Right? So I've served, for example, as a child welfare professional for 13 years. And as a child welfare worker, when I'm knocking on the door of a woman who is likely single, likely impoverished, and likely threatened ... feeling threatened by her general environment, I have to be self-aware that that woman will be opening a door to a Black man of a certain size and it's my job, as the professional, to know how that person is likely going to respond to me.

So a police officer who wears a uniform and a flak jacket and a gun, who embodies and represents policing with all of the warts and pimples of policing in the 21st century that we've become tragically aware of, has to know that when they call on a person of African descent how that person will be interpreting them in the lens of all of that history. Right?

And so for police officers to not be aware that different people ... they need them to approach them differently based on this complex mix of history and experience, for a police officer not to understand that would be naive policing. And when a

person wields tremendous authority, they have a real burden to understand how that authority is being perceived by the people that they wield that authority with.

Q. Thank you.

MS. JORDAN: So, for instance, when the police are called and it's a Black woman, for instance, who has called the police and police arrive at the home, typically what I would imagine you would see is a woman who is calm, cool, and collected. She's presenting in a certain way that is a protective factor for her. She may appear that she's entirely together where, inside, she is falling apart. Okay? That's one of the personas that, as Black women, we often portray. We could be totally anxious, fearful, et cetera, but to show any instance of vulnerability reflects on us as a Black woman, that we're not strong. So we fall into those stereotypes, the strong Black woman.

And when the police arrive and it is a Black male, we must understand it, too, from a historical perspective. Policing in terms of during slave times was used to control and to keep. You know, we wouldn't call them "police" back in the day, but the folks who traveled the cotton fields who kept the slaves in line, you know, kept them on plantations.

You know, we look at that historically and then we look at policing today and the criminal justice system. Oftentimes, from a historical perspective, it's not about help. It's about control. And it's about ... you know, it's not about, How can we help you? How can we harm you? And that's historically what Black people have experienced in North America. It's harm by systems and not necessarily help.

(14:20)

So when Black men run from police, they may not be necessarily running because they have done something. They may be running because they fear what police will do to harm them.

Q. I'm wondering ... oh, sorry, Ms. MacLean. I didn't know if you were going to say something.

MS. MACLEAN: I was. I was thinking in terms of the whole concept of relationship. And what we do know is that in those rural Black communities, police actually know who the people are in each of those rural communities who are the "likely suspects". And, you know, as Mr. Wright said, when you come into those spaces and places where somebody like Mr. Desmond, who maybe hadn't been known to the police for other ... maybe potentially other behaviours or other risk factors that he presented with, or there's certain family names in certain

communities that get highlighted and that family becomes known, I think when we look at how policing happens in rural communities; one, it's mostly RCMP policing and not like, you know, like city police. That those relationships are things that I think have to be intentional to develop in these communities. They're small.

You know, if you ask somebody in Sunnyville, Who are the RCMP officers, I'm sure they can tell you who the three or four RCMP officers are, where they live, and what their shift is, right, as much as these officers can tell you about who lives on certain streets in other locations.

So I think it's really imperative that when someone shows up to speak to people in their homes or in their communities that that relationship has to be built upon and that there has to be a warm transfer from those policing agencies from one to another around how they hand over a shift. Because, you know, they do their 12 hours and they have to do a warm handover to the next group of folks how are coming on to say, Listen, we were just at so-and-so's house. These are some of the things that got flagged. You might want to do a wellness check on them somewhere during the shift.

Those are the pieces of like warm handovers or warm

transfers that would be beneficial in terms of wellness checks within certain communities or certain families that, you know, that may have called but just was like concerned. Well, Black folks don't call police with a "concern" most times. We call the police because we're looking for an outcome because we're trying to give and look for the best possible way to get someone taken care of and because of some of the restrictions and ... you know, I just think ... I always tell my ... when I do teaching, I always tell psychiatrists and mental health practitioners, When Black folks present at emergency departments or where people call the police, it's not because we're curious or we're looking for a wellness call. It's because there's a crisis and we don't know how to articulate that. So we're asking you to have enough cultural competency to actually ask me the different kinds of questions in different ways. So I leave it with that. I think ... you know, we don't show up unless there's a crisis.

Q. I want to bring the Panel's attention to it's page seven of the report and it's the last paragraph on that particular page. If you can bear with me, I'll read in that paragraph into the record and then there's a series of questions with it and particularly based around ... I think it's something

Mr. Wright had touched upon earlier, that from the perspective of an African Nova Scotian male and the uniqueness and importance of sort of that recognition and services geared towards that particular person. So in that paragraph, and there's a lot in there, it reads:

> Mental health in the Black community is something that can easily be unchecked or left untreated. When it comes to mental health, people tend to suffer in silence which often applies heavily to Black men. Years of racial oppression and the inability to react or speak on an emotional level left many Black men conditioned to suppress their emotions. You were born into a world where you were considered less than and reminded of it constantly. You were forced to form a tougher exterior and put mental and emotional well-being on the back burner just to survive, a mentality that has been passed down from generation to generation. Black boys and men are taught that they must be strong and tough because the world is ten

> times tougher. They grow up and are taught there are people who don't like you because of their skin colour. It is tough to swallow but they must come to terms with it quickly.

So there's a whole lot in that paragraph and I guess if we could start with breaking it down in terms of the clinicians, I guess, came to know Lionel Desmond as someone that was diagnosed with PTSD, depression, anxiety, substance use. They became aware of some of his family and life stressors.

This particular analysis never did appear in any report or in any sort of testimony and I'm wondering if you could elaborate as to ... I guess break this down for us in terms of why it's important for clinicians and healthcare providers and family intervention services providers to appreciate this and understand this, and what does it mean.

Again, sorry for the long question.

MR. WRIGHT: What does it mean? It means that a mental health clinician cannot treat a Black man unless they understand this, period, full stop.

Q. Okay.

MR. WRIGHT: This experience in terms of Black male

mental health is ubiquitous. I'm not sure, and given the history of North America and given that Black peoples are founding peoples in North America, you know, with when Europeans came to North America, they brought Black peoples with them on the first ships that they came in.

So given the ubiquity of this experience for Black men and given how long we have been here, it seems to me incomprehensible that a mental health clinician could consider their training complete if they did not understand that this is the experience of Black men.

MS. JORDAN: And if I could just add to that, there was a documentary released in 2015 entitled "The Mask You Live In". It speaks about masculinity in terms of all men, but it's particularly true. And they did a wonderful job in this documentary depicting how the formulation of masculinity and how that impacts our Black men.

We talk about in this paragraph in terms of, you know, Black men suffering in silence, the way that they feel, not being able to express their emotions; you know, that folks are, you know, depressing their emotions or bottling them up for, you know, lack of a better term.

We look at CBT, cognitive behavioural therapy. We look at

thoughts, feelings, and behaviours. If a Black man thinks that he is lesser than, and he's receiving all of these messages from the society which he lives in, then that impacts how he feels about himself and then it impacts the behaviours they exhibit. Like this is ... you know, CBT is, you know, a therapy that is evidence based.

And then we look at like, you know, showing vulnerability in our ideas and how society constructs what is vulnerable. And one thing we definitely don't want to look like in society, as Black people in general, is vulnerable, particularly Black men. So there's all this posing that takes place and behaving in a certain way that depicts to the public that, I am not vulnerable. In essence, what we are are vulnerable.

We look at Brene Brown's work in terms of vulnerability in talking about expressing vulnerability as a strength versus as a weakness. These are the essences in terms of the pieces in which clinicians don't get an opportunity to get to because of the barrier within themselves and not being able to identify that this is not a strength, that this is a vulnerability. And then how do we get to those vulnerabilities and how do we get to working on expressing these emotions?

(14:30)

Because we know that when we suppress emotions and suppress experiences, it's like a bottle under pressure. So we have a capped bottle that's constantly under pressure and these feelings, these emotions are being suppressed. No place at all, even when we go within the healthcare system seeking help, can we express these emotions, because clinicians don't have a way of understanding and navigating and maneuvering to get to those emotions, particularly with Black men and Black people in general because of the stigma that, you know, This person is aggressive.

So when a Black man walks into the office with say, for instance, a white female clinician a Black person is automatically going to feel that this person is not open and warm and receptive so this is not a safe person; I can't express how I'm really feeling with this individual. That's at the core essence of therapy. So folks have these stigma and these ideas around what Black men are, what Black women are then they just basically they don't get therapy.

MS. MACLEAN: If I can build on what Cynthia and Robert were speaking to clinically, and with the particular nuance to Mr. Desmond, to Lionel. So if you're taught in your family community not to show vulnerability, you go into a profession,

into the military, which actually reinforces that, that you cannot be vulnerable, that you have to have a particular exterior, the analogy of the bottle being shaken it's twice the amount of pressure that someone like Mr. Desmond is under.

So, you know, I can't find safety to express my feelings in a clinical setting because I've been trained at home or in a community because of racism and I've been trained very specifically in a military, you know, basic training to whatever other trainings he's had around how to remove yourself emotionally from situations that you're involved in when you're in theatre. So I think there's some complexities that are even layered around the intersectionality for Mr. Desmond that, as a clinician, someone should have been able to interrogate slightly differently.

That if the context of who I am in my discipline or in my career has taught me certain things but I'm curious if anyone has looked at how race and culture has also compounded on that as well. So a clinician should be able to say well, Where else did you learn this; How do we want to interrogate vulnerability; How do we want to interrogate depression and trauma and what are the intersectionality pieces of that in your life and how did they get ... oh go ahead, Robert.

MR. WRIGHT: No, if I can just say one thing, and again I don't want to get into the territory of duelling experts, but the fact that you have had testimony from mental health experts and these issues have not come up through them, is indicative of the challenge that we speak to today.

Lana and I have been involved provincially in mental health reviews and federally in mental health reviews. We would be perceived and again, you know, I'm not disrespecting Ms. Jordan's expertise, but I'm saying we would be perceived as leading experts in mental health service delivery in Canada as it relates to people of African descent and I think we have a pretty good handle on what those issues are. The fact that that knowledge isn't more widely distributed within our systems and isn't taken up by white members of our professions is indicative of the systemic racism that we talk about.

Not to suggest that the clinicians that you have spoken to are themselves racist, but that the systems in which they have worked, the schools in which they have studied, even the professional development that they have been exposed to once they have entered their system of a service delivery has left them devoid of the kinds of things that we're sharing with you today, and that, I think, is fundamentally what must be changed.

MR. RUSSELL: And along those sort of lines, repeatedly throughout the Inquiry we learned there was a phrase "instability" and that was very often used in Lionel Desmond's interactions with healthcare professionals.

For example, after he leaves the Canadian Armed Forces and he's involved with the Operational Stress Injury Clinic in New Brunswick a psychologist and a psychiatrist indicate that they can't get to trauma treatment for his trauma just as it relates to the military because they say, We can never achieve stability with him.

He goes to Ste. Anne's, which is a residential stabilization in-house program with access to many professionals and they indicate, We cannot reach stability with Lionel Desmond to get to trauma treatment just as it relates to PTSD in his military. Not talking about all the other stressors and situations he's trying to navigate.

This broad concept of mental health stability or instability, I guess from Lionel Desmond's perspective as an African Nova Scotian male, what factors into his stabilization as it relates to being culturally specific as it relates to him?

MS. JORDAN: So in terms ... sorry, Robert, would you like to go first or should I?

MR. WRIGHT: You go ahead, yeah.

MS. JORDAN: Okay. In terms of stability, oftentimes within systems when we're working on, you know, issues of trauma or other mental health issues oftentimes that stability refers to substance use that's involved.

So if someone does not have stability around substance use then working within the mental health part of the person who is presenting with a concurrent disorder oftentimes it gets in the way of treatment. I've seen many folks who've gone through treatment and cannot gain stability in terms of the substance use disorder. Because we know that substances blocks emotions, okay. It helps to numb the emotional state of the person.

So when we think about stability, oftentimes within treatment programs sometimes it means that the person is presenting, they're still actively using. It may also mean that the person hasn't been stabilized in terms of trauma treatment there's a stability period which means that they have some coping skills, they've developed some coping skills that will get them through a period of time.

In treating someone with concurrent disorders such as PTSD and addiction it can be quite complex. It requires multiple teams or multiple skills of individuals on teams, not just

someone who necessarily works with the trauma piece but also has the addiction specialty as well, or at least the two are working together in order to stabilize the individual.

It may be a common misconception that, you know, if you go for trauma treatment then you're going to actually receive addiction treatment as well. Not necessarily true. Someone can go to trauma treatment and still be actively using up until the point that they are actually in the trauma treatment.

So it may have been, and I don't know, as Robert said, I personally I worked for the Department of National Defence but I have not worked specifically with Mr. Desmond but I'm only using my knowledge and my lens of what happens within systems often. So when they talk about instability I believe that instability probably had something to do with the substance use part of it as well as the foundational part in terms of developing the coping skills. And I think that one of the biggest issues with getting to that point would be the lack of cultural competence within the systems.

MR. RUSSELL: I guess I perhaps should have phrased it a little differently in terms of at the time that they're saying instability they certainly weren't suggesting that he was at the time maybe actively heavily consuming alcohol. They talked

about it more from sort of a mental health aspect. They couldn't get to trauma treatment because there was so much happening with him and he was destablized.

MR. WRIGHT: Yeah.

MR. RUSSELL: So in that context I'm wondering perhaps I guess Mr. Wright ...

(14:40)

MR. WRIGHT: So, yeah. Sometimes in trauma therapy we often talk about the triphasic model of trauma treatment where the first phase in treating trauma is helping the person find calm. Calm or stability, right.

I think as Ms. Jordan mentioned sometimes if there is active substance use you're certainly not going to get to the trauma until you settle that down. But often with people who have fairly complex and intersectional lives the thing that you need to do to help them find calm is to engage with them and their issues, right.

Probably one of the examples that I can give of this, and again forgive me for the example but it's illustrative, that I am sometimes contacted by the formal mental health system when people get stuck in that system. And I remember quite some time ago a colleague calling me and saying, Robert, we have a trans

woman who's in our short-stay unit, we can't get them out, they're stuck. They're a multi-emergency room user; they're at the emergency department seven, eight times a month. They're in the short-stay unit two or three times a month, can you try to help them.

Now this is a person with a long history of trauma, deep trauma, complex trauma we call it today, but the reason the system was having trouble helping her find calm was because they could not engage with her as a trans woman who was Indigenous who was dealing with all of these additional things of race-based trauma and trauma based in her sexual orientation and gender identity.

So as a queer Black person I was able to engage with them and work with them so that they could see that they were being understood and once engaged in that therapeutic trusting relationship because of my awareness of her intersectionality, we were able to then do successful trauma work.

This is often the case, this inability to engage to help a person calm in order to begin trauma therapy happens disproportionately with people who live at the intersections: queer people, Indigenous people, racialized people, immigrant people. And it's that first piece of engagement that our

systems have a really hard time with with people of African descent.

So, if someone was not engaging ... you said that none of the other clinicians you've heard from have talked about Mr. Desmond as a Black man. Well, is it possible, and again I do not want to come across as knowing better than those clinicians or competing with them, but is it possible that understanding Mr. Desmond as a Black man would have been essential to engaging with him to enable him to find the calm that would then allow us to get into his trauma?

It's a question. You know, I realize that I formed that as a question but it is a possibility.

MR. RUSSELL: And that was definitely the purpose, is to sort of get a perspective in assisting the Court in sort of understanding what stabilization could have perhaps looked like for Lionel Desmond and, again, at the end of the day that is for His Honour to figure out, but when we get the whole perspective it's certainly very helpful.

MR. WRIGHT: Yeah. Not to prolong, but I just would say that Ms. MacLean and Ms. Jordan and I all do impact of race and cultural assessments that are done disproportionately with Black men. And part of our work with folk is to engage with them so

that they can participate in the assessment process. And our ability to engage with them is based on our ability to say, Hey, I see that you are a brother, how can we help you to tell your story? We understand some of your story by virtue of knowing that you're a Black man, right.

MR. RUSSELL: And with that do you see some value in Lionel Desmond's transition from military to civilian life and how it intersected with various mental health entities along the way? Is there value in a concept or an idea of engaging in that sort of assessment but in a military to civilian life transition for someone who is African Nova Scotian?

MR. WRIGHT: Absolutely.

MS. MACLEAN: Absolutely.

MR. RUSSELL: In terms of your report, at page 8 of your report, I'm just trying to find the spot, it's the second-last paragraph and it's the third-last line and it starts with "Despite the challenges..." I'll just read it. "Despite the challenges Black men often experience, it is important to note that Mr. Desmond reached out for services but such services did not appear to respond to his need. Such factors which could be considered relevant are noted above."

I wonder if you could expand upon that and explain what do

you mean by ... we know he reached out for services, in fact he was very proactive in trying to do everything he could in his abilities to get the help he needed, but you noted that services did not appear to respond to his need.

Without trying to be too diplomatic and polite, I wonder if you could sort of expand upon that from your perspective of expertise and what do you mean by that?

MS. JORDAN: Who do you want to answer that question? Robert?

MR. RUSSELL: If everyone wants to answer we can go in turn for sure.

MS. JORDAN: Okay. So I guess I'll go first.

So "Despite the challenges Black men often experience it's important to note that Mr. Desmond reached out for services. Such factors which could be considered relevant as noted above." And those factors are the disparities in the lack of treatment, culturally-specific services in terms of the things that we've noted throughout today: systemic racism, the lack of culturally responsive services within the healthcare system. So he was reaching out apparently, according to reports, but such services just basically did not exist in terms of how he needed the services to respond in terms of how Robert expressed in terms of

engaging. You know, folks are going to go for services necessarily but they're not necessarily going to engage in services if they meet with resistance or a lack of understanding in terms of what their specific needs are from a cultural lens.

MR. WRIGHT: The other thing that I would add to that and, again, I don't need to be dramatic or salacious, but as a Black man of a certain size I have to be aware of how I am perceived when I go out in the world seeking services.

When I'm unhappy with a service or a product that I have purchased I will often engage with people at a customer service desk and very politely say, I think that this is a problem that we can't resolve and that perhaps we should get some help in resolving this problem. And I always say that because I understand that if I get agitated at the customer service desk that I can make a person on the other side of the desk exceedingly uncomfortable by my size and my race.

What I'm saying is service providers are not immune to this concept of cultural intimidation. The idea that service providers can be frightened by how certain clients present that hinders their ability to engage with such clients.

I think that if a person is not well, if their emotions are not under control and that person is a Black man seeking

services, I often wonder if the inability to serve that client is mixed up with the service provider's inability to feel comfortable and competent and confident and safe providing services to such a person.

Now that's a dangerous thing to say out loud, but this is the place to say it if no other place.

(14:50)

MS. DAVIS-MURDOCH: Yeah.

MR. RUSSELL: Yes.

MS. DAVIS-MURDOCH: I would just like to add, certainly not as a clinician but as an observer and as a person who has advocated for better services, something that we have repeated and, you know, I don't even know who said it first, but that for a lot of Black people, particularly Black men, the first interaction they have with the mental healthcare system is in the back seat of a police car.

So the criminalization of mental illness is a reality that we are very aware of. And as people in community you are concerned that that is where even reaching out for service is going to take someone you love and care about as a community member, as collective people, and certainly as a Black woman you would be so concerned about that for your father, for your

husband, for your boyfriend, for your son.

The suffering of Black mothers worried about getting service for their children is such a familiar theme that we have heard in the Health Association of African Canadians from the beginning. How do we trust the system to care for our children, but particularly our male children, and what is the risk that we have to calculate in order to get care when we know how the system responds.

And in this period of our evolution as people on this planet and particularly in North America, you know all too well that this time of Black Lives Matter-ing or not, this time of police brutality, watching on television the murder of young Black men, of children being apprehended by being in the wrong place, simply by being in the wrong place, this informs our anxiety, it informs our mistrust and it does so on an ongoing basis.

So I am not a clinician but I am an observer and a policy person who can tell you that that impact is significant for our populations I would say across the African diaspora.

MS. MACLEAN: I just wanted to speak a little bit to what you spoke of Mr. Russell, about Mr. Desmond seeking out and seeking out. I want to speak to the resilience of his character

in seeking out support. While you're psychologically distressed, he's doing all the labouring, he's doing all the work to connect with a service or service providers that will hopefully match his psychiatric and cultural mental health needs.

And I just want to just pause for a moment to say he did his best with what he had in terms of the resources that were at his fingertips. The resources didn't match his psychological wellness or his cultural wellness or took notice of that in a meaningful way. And I think it's really important to recognize that as much as he was psychologically vulnerable he was still seeking support. He was still looking for those resources and we failed, "we" the collective society, to meet the needs of a young Black man who was suffering and still wanting some resources and just there was just no fit. So he was, you know, perceived as the problem, not the service delivery agents as the problem or the services themselves.

So I'd just like to pivot to say for as much as his behaviour led to all this fatality, here's a young man Black man who struggled to figure it out and there was no real place for him necessarily to land that actually had enough cultural clinical humility to say, Oh, why don't we case conference Mr.

Desmond? Let's look at who can we leverage in the community to help us, as Robert said, figure out a different clinical plan of care. Everyone was siloed as he was trying to connect the dots.

MR. RUSSELL: I'm wondering, Your Honour, I have one more question that's probably related to Ms. MacLean would be able to answer, it's about the community, and then it would be into the recommendations portion.

THE COURT: All right. I understand, Ms. MacLean, that it's about 5 to 3 or thereabouts. I understand that you might have to leave us at 3 o'clock?

MS. MACLEAN: I can get to 3:15, Your Honour.

THE COURT: All right. Well, what I'm going to do then is maybe we'll have Mr. Russell address that question that he has in particular to you at this time and we'll go to 3:15 and we'll take a break at 3:15 or if we're concluded the question and answer for you, and we'll take our afternoon break after this question then. I take it that hopefully the others can continue this afternoon with us for a while? All right. I appreciate that ...

MS. JORDAN: Yes.

THE COURT: Thank you. Go ahead, Mr. Russell.

MR. RUSSELL: So, Ms. MacLean, you're in a bit of a unique

position in that you have information that you can tell us what Shanna Desmond, Lionel Desmond, Aaliyah and Brenda's and their families' community, what their perceptions were of their experience in accessing resources after the tragedy.

I'm wondering if you could tell us very briefly what were some of the things you heard from community members after this tragedy and specifically as it relates to resources or maybe the lack of resources.

MS. MACLEAN: Certainly. Post the fatality when we went back into the community there was a lot of folks struggling psychologically with trying to understand what has happened and its impact on the community's mental health and mental status. People were activated themselves and needed a space and we had the privilege of providing that space when we were offering those sessions for people to get to a place, as Robert said, of calm.

So people were speaking to the fact that, you know, a lot of young Black men who choose the military as a career, particularly from the Sunnyville, Lincolnville and Upper Big Tracadie communities realize that these young Black men are, you know, fractured when they leave and go into the military, when they come back they're no longer fractured, they're completely

broken. And people were struggling with how do we put and support these young Black men when they were, you know, had their own vulnerabilities prior to going in and then coming back completely broken. And folks were struggling about how do we help these young Black men.

The community was extremely traumatized, as I said before, around how do they support the kids who were hearing and witnessing and looked ... and feeling overwhelmed by what we call the latent trauma or the vicarious trauma. Even though they weren't there but they're actually like speaking and witnessing and talking about the impacts it had on the community overall. Hence why the African United Baptist Association provided some free counselling to individuals and families and community at that time doing drop-in wellness sessions for them.

I think the community even to date recognizes that for a young Black man in those particularly three communities the only positions or jobs that really were afforded to them were in the forestry. And these young Black men saw going into the military right out of high school, you didn't have to have a GPA of 85 or 90, that they could move into the military, get a career and be seen as someone who is elevating themselves out of poverty, moving into another space where it's not just connecting to

their psychological wellness that they are thinking about but creating a legacy of financial stability for themselves and their family at the detriment of their mental health. As we spoke to earlier that they're already coming in psychologically vulnerable and then learning to suppress that vulnerability even more through their training and coming home with very limited resources and supports because particular in rural Nova Scotia they're just not necessarily there.

And there is still a history of systemic racism within, you know, Nova Scotia communities, particularly rural communities. Don't forget those communities are segregated communities. And so having access to resources and supports, the community just felt like everyone and all systems were basically on failure to them.

(15:00)

And as Ms. Davis-Murdoch spoke to, the community then pivoted back to what we know best from a cultural community lens, which is that let's take responsibility and make the ask for what we need and that ask all came from Black clinicians and Black pastors to do some level of healing in the community. Not enough but just enough so people could at least have some understanding that people were hearing them and that they could

process some of the trauma that they were experiencing.

And other disclosures were happening in those sessions that we were holding around, you know, disclosures around intimate partner violence that was happening at other people's homes, not knowing how to navigate the resources or supports in their community. Feeling like, How do I get to Naomi House? How do I get to these services when I don't have active transportation?

They were looking at all the barriers to access to care when we were looking at what are the local resources that you have. And it was really quite difficult for the community to come up with two resources outside of what they already did not know: their families and the church. Those resources were the only two things that they felt safe enough to access.

And what we do know is that a lot of those families articulated it's hard when intimate partner violence is happening in your home because, you know, the people that you would want to go to for safety are cousins to the person who's perpetrating the violence against you and/or that they are like familiar dynamics are very intimate in rural communities.

So finding a place of safety, even within the Black community that they are located in, became problematic. And usually it was like, Okay, better to have a place to go to and

suffer through those, you know, violence, because some people in our community still say, Well, he's still a good man because he brings home some money, right. So, you know, he still pays for the bills. So there's all these particular cultural nuances about why some women stay, including financial security, their children is another. But there's all these repercussions that in rural Nova Scotia, particularly in Upper Big Tracadie and in Lincolnville and in Sunnyville that are very specific to those communities.

And I also, to my knowledge, is that those three communities have had a longstanding history of young Black men going into military service because it is a way out of poverty and they come back and they are fractured if not damaged.

MR. RUSSELL: And finally, sort of, in terms of feedback you got, you know, the Province has ... I found this interesting at page 9 of the report, the Province has mobile crisis as well as, you know, resources in hospitals which could be St. Martha's in Antigonish and throughout hospitals in Nova Scotia. And you indicated that the response ... and it's in quotes, "It's not mobile down here for us. You're better off if you can get a drive going to Sydney."

MS. MACLEAN: Yes.

MR. RUSSELL: Now is that something that's concerning to you in terms of, in theory, the Province has resources but in practical terms it appears to be almost a moot point because it's not accessible in a rural community such as the ones in Guysborough?

MS. MACLEAN: Absolutely, Mr. Russell. I mean mobile crises really is not even completely mobile within HRM jurisdiction. If you fall outside of, I believe it's the Dartmouth catchment or in the Central Halifax catchment, they're not coming to see you.

So the mobility of a mobile crisis team is a moot point for anyone outside of Metro Halifax. The only accessibility is a 24- hour contact line and most times a lot of people, particularly I go back to saying when Black folks reach out for clinical support we're looking for an immediate contact. We're not waiting to be put on hold for 45 minutes to an hour to say, Leave a message and I'll get back to you, which is some of the ways in which the mobile crisis phone line is actually supported.

I do believe with the work that HAAC, the Health Association of African Canadians and ABSW did with the COVID response line that they actually got a better reception to

people across the province around from the Black community accessing that support because they felt that it was culturally safe for them to access it. And they are actually getting calls around intimate partner violence or how do I navigate getting mental health supports outside of just COVID supports. Again, it is a culturally responsive tool.

And for people to say that it's better to go to Sydney than to go to St. Martha's that's a pretty darn long drive, it's another two and a half to three hours because they feel that, you know, there is some ... if I understood the comment in its context from the person, is that if I go to St. Martha's it's usually understaffed, I have to wait. And if I go there at midnight then there's no clinical support in place and I won't see someone for 48 ... 24 hours later so I may as well be discharged home or I may as well just leave AMA. At least at Sydney there's a mental health crisis team available to be seen in the emergency department.

MR. RUSSELL: Okay. With that, Your Honour, I wonder if we could move to perhaps break and then the intent would be to review the recommendations that are at the end of the report.

THE COURT: All right. Thank you. So we'll take perhaps a 15-minute break and I'll give you a callback time in a

minute.

But just before Ms. MacLean leaves. Ms. MacLean, thank you very much for your time today. And we appreciate the time you spent with Mr. Russell in preparing with the group before today. And I know that you would have taken some time to put your thoughts together, and the paper that you provided is, I speak from my perspective, it's very useful and insightful for me to understand in a more practical way some of the issues that face not only the African Nova Scotian community but as they relate to Cpl. Desmond and his family as well. So, again, thank you very much for your time, we certainly appreciate it.

MS. MACLEAN: Thank you, Your Honour. Thank you to my colleagues.

THE COURT: Thank you. We'll take a 15-minute break, come back at 25 after the hour then. Thank you.

COURT RECESSED (15:07 hrs.)

COURT RESUMED (15:27 hrs.)

THE COURT: Mr. Russell?

MR. RUSSELL: Thank you, Your Honour. So I guess the final portion of, I guess, the evidence from, I guess, a traditional direct examination perspective is in your report at page 9 "A Way Forward" this, I believe, is where you put

together five, I guess, recommendations for the Court to consider and reflect upon.

I guess if we could start with the first one that talked about a partnership, a recommendation as it relates to partnerships. If you could, rather than me trying to paraphrase out of the report, if you could maybe articulate what that first recommendation is at page 9.

MS. DAVIS-MURDOCH: Well, I can start and then again I invite my colleagues to add to it. Certainly what I get from that and, you know, this was a collective effort, was that we need to integrate the work of the Association of Black Social Workers and the Peoples' Counselling Clinic in to the delivery of mental health services in this province. And as was mentioned many times the importance of the perspective and skills of people who are outstanding in this area of mental health and specifically to do with the improved mental health of people of African ancestry.

There's also reference to a virtual opportunity here, because, as was stated, the majority of practitioners live in the HRM and the undersupported, and I would dare to say underfunded, area of mental health care is particularly the case in the rural areas.

So it will need to ... so I feel that this is about the integration of Black providers who could significantly improve care and to make it accessible to do that virtually in a way that people can actually use because internet service in rural Nova Scotia is a problem, so that's part and parcel of making this actually work. But that as services continue and as new services are added they cannot be done without the integration of Black health professional to support and improve the services.

(15:30)

MR. RUSSELL: Okay. If there isn't anything else from the Panel I can move to the second recommendation.

MR. WRIGHT: No, I would only add that the mention of the Association of Black Social Workers and the clinic that I had, the Peoples' Counselling Clinic, I think are identified because those are the two locations where practitioners have been located historically who do this sort of work. So the Association of Black Social Workers being a non-profit organization of social workers and the Peoples' Counselling Clinic being a non-profit organization that has delivered mental health services to Black populations in the community and, in particular, in special university programs where that has been

contracted with us to do so ...

MR. RUSSELL: The nature of this Inquiry is, I guess, provincial in scope and this recommendation applies to the Canadian Armed Forces that you had set out, but I could certainly see the principles applying to maybe the Nova Scotia Health and the other various departments it contracts with. But if you could explain what the second recommendation is and why, I guess, it's meaningful.

MS. JORDAN: So the second recommendation is about recruitment and retention of African Nova Scotian clinicians within the current systems that exist, those being provincial systems and federal systems as well, so that we have individuals or champions within those systems who can provide leadership within the systems. And that speaks to, you know, advocacy and awareness in regards to specific concerns that are particular to members of the African Nova Scotian and diverse communities. So that is seeking and retaining qualified healthcare professionals who provide culturally responsive care for active and retired military individuals. So those are across the system just so that it doesn't exist within one system but it's not limited to the provincial but all systems that have health mandates.

MR. WRIGHT: I would just add that that recommendation

recognizes that recruitment and retention of those mental health service providers is going to require a special, uniquely tailored supports for those people who work in the systems.

We should realize that if systemic racism is real and the stressors and the trauma of race is something that our clients deal with that those of us who work within these systems are not ourselves immune. So to invite Black practitioners into these formal systems that have a legacy of systemic racism requires that those systems acknowledge that and provide the service providers that they recruit into those systems with appropriate services to ensure that they are able to be supported and that will improve retention.

Not to get overly personal, but I certainly have been involved in supporting a provincial network of mental health practitioners, many of whom no longer work within the federal or the provincial systems. In front of you today are two such individuals. You know, myself, having worked in child welfare and in government now ply my trade in a community-based non-profit. Ms. Jordan has worked in both the provincial and the federal systems and now she plies her trade in a community-based practice. I think that these things should be taken note of and the needs of those healthcare providers should be especially

attended to.

MR. RUSSELL: Okay. The third recommendation, the comments in relation to bystander effect and the recommendations that have come out of that. I wonder if you could articulate that for the Court, what the recommendation is and why is it particularly important.

MS. JORDAN: Would you like me to go ahead with that, Robert?

MR. WRIGHT: Yes, please.

MS. JORDAN: Okay. So when we talk about addressing domestic violence or interpersonal violence and the African Nova Scotian community it must come from a cultural lens. And when we take a look at bystander effect it means to address the access of resources and supports.

When we talk about that we talk about actually how do we advocate, right, not only within the African Nova Scotian community but other individuals who are allies for anti-racism and anti-oppressive services, so just recognizing our fellow colleagues who also come alongside and are able to help and provide services that are culturally responsive. So somewhat of a system that addresses aligning with service providers in the process of providing services.

And these are all like issues that address the social determinants of health. We talk about awareness, advocacy and aligning services to African Nova Scotian care delivery. So yeah, so it's understanding that it's an integrated approach and not just a one-prong approach.

MR. RUSSELL: Okay. Anything else from the Panel before we move on?

MR. WRIGHT: No, I think we're saturating these things.

MR. RUSSELL: So the second-last recommendation seems to be directed towards perhaps Nova Scotia Health, and I wonder if you could tell us a little bit about that recommendation.

MS. DAVIS-MURDOCH: I would add that it may be Nova Scotia Health insofar as we need more providers hired by Nova Scotia Health, but I would also say that when it comes to educational scholarships there is work that continues with promoting leadership in African Nova Scotian Health which is a program at Dalhousie looking at the recruitment and support ... well, not so much the recruitment but the recruitment of health professional students and then supporting them to success throughout their student journey and then certainly also being there to help with mentoring as they begin careers.

So there is work that HAAC is directly involved in and was

instrumental in the beginning with plans. There is also other scholarships, certainly the Dartmouth General Hospital Foundation has just begun scholarships for high school students, you know, looking at the whole kind of opportunity to inspire young people to move into the health professions and then support them to success.

What we need is a comprehensive view of about how to attract people of African ancestry into the health professions, how to support them to success, how to ensure that they are hired and that they become part and parcel of the health system at every level. Certainly with respect to primary healthcare teams, that they are members of those teams, that they are ... you know, collaborative teams are about, as they say, one plus one makes three. Because when you have, you know, each member providing particular skills at the end of the day you have a better provision of care and it is, in fact, multiplied, the effect of that good care.

(15:40)

So having representation at the primary healthcare level at the acute and tertiary care level it doesn't specifically, I suppose, focus on the Desmond Inquiry but the importance of even continuing care when we think about dementia care and so on. So

it's the whole trajectory of mental health care from children to seniors as Ms. MacLean spoke about.

So all of those areas of care need to be improved by the continuous growth and representation of our people throughout the health system.

MR. RUSSELL: And consistent with what you had indicated earlier on in the evidence is it fair to say that this recommendation in terms of recruitment and retention and promotion of those resources, it's not only true in the classic mental health setting sense but also mental health as it relates to family intervention services, domestic violence services as well. Is that fair?

MS. DAVIS-MURDOCH: It is. A holistic approach to this. Health being not just the absence of disease but all of the ways in which the social and structural determinants of health are understood and impact the system. So absolutely you are correct.

MR. RUSSELL: Okay. And the last recommendation to me, I guess, seems it's very broad in the sense that it talks about a network. I wonder if you could explain what that recommendation is and the importance of it.

MR. WRIGHT: Well just remembering that there is a

network of Black mental health providers here in the province that that group was initially brought together in that work that HAAC led as a result of the provincial review of mental health and addictions.

Well, we did talk about the fact that that network was abandoned by the system after the project terminated. And some of us in the community ... well, perhaps I'll be plainer and say that at the Peoples' Counselling Clinic we've kind of reawakened that network and are trying to knit it together without supports and resources.

And so this recommendation goes to acknowledging that network of professionals as an important support in doing this work and that supporting them is a key to the expansion of culturally competent mental health and domestic violence services.

So these practitioners wherever they are located and in whatever disciplines they practice, whether it's nursing, counselling, social work, psychology or community-based family service delivery that there is great potential in those folk forming the core of this culturally competent mental health and domestic violence service delivery network. And so that being the case, we're recommending that it be supported.

MR. RUSSELL: Okay. In terms of I guess, to conclude, there was a great deal of inside expertise and information provided here this morning and I believe it's fair to say that it certainly goes beyond five recommendations at the end of your report.

I guess is there anything that perhaps I might have not have asked about or asked/invited the Panel to explore, I would certainly wish to give you an opportunity to do so before we conclude this portion of the evidence, I guess, this afternoon.

That's either a good sign or a bad sign.

MS. DAVIS-MURDOCH: I would just ask my colleagues to underscore the importance of building Black health infrastructure. As I had mentioned earlier, that has been in the vision of HAAC since our establishment. We need to build infrastructure in administration, in service delivery, in every area of the health system, in every area of the social services support system.

MR. WRIGHT: Yes.

MS. DAVIS-MURDOCH: We need our people there. We need to be integral to the success of good healthcare delivery and for there not to be ... I think, you know, my colleague, Mr. Wright, outlined that so beautifully when he talked about a compare and

contrast which is always so useful when you look at education and what that infrastructure has produced, how it was built, the response of the various governments of the day. You know, we've had three governments over the time that this work has been done. No one government has done good things, all of them have and all of them need to do much, much more. So, I think, you know, in drawing that comparison you can see what is woefully lacking and I'll leave him to underscore that.

MR. WRIGHT: Well, again, as I said, in education we have the Black Learners' Advisory Committee report that resulted in the infrastructure that we're seeing today. Nearly 40 years of building infrastructure and now we have people of African descent in every school district, in administration, an African-Canadian services division, student support workers, Black guidance counsellors, that was the moment.

If we looked in Justice, for example, we had the Marshall Inquiry which led to the Indigenous, Black and Mi'kmaw program at the law schools. And now we are finally, some almost, again, 30 plus ... almost 40 years later we are having the effect of that in terms of a record number of judges of African descent and Black professors at the law school, Indigenous, Black Nova Scotians and Mi'kmaw people teaching at the law school. And the

infrastructure is beginning then to make its way through the defence systems, through the prosecutorial systems and the judicial systems in Nova Scotia. And Nova Scotia is a leader of in the field of IRCAs and now we are leading that nationally. We need a similar kind of movement in the field of health.

And it was Senator Kirby who said, I think, that mental health is the backwater of the health system. So if we need it in health we need it all the more in mental health. And I think that he went on to say that if mental health is the backwater of the health system then children's mental health is the backwater of the backwater. And so we need this infrastructure in these systems and perhaps this will be the moment that we spark the need for that and then follow through with the infrastructure that Ms. Davis-Murdoch spoke of needing.

MS. JORDAN: Absolutely. Thank you. And I would just add to that in just stating that it would be a great way of moving forward by recognizing that racism and culture is a determinant of health, especially in the Province of Nova Scotia where we have such a history. We have generations, you know, 400 years of history here in Nova Scotia and Black people quite frankly have not always been treated fairly.

And Dr. David Williams talks about racism in terms of the determinants of health, the literature, the research is there, the impacts of racism on health of individuals, on health of Black communities. So recognizing that it is, I think that's the first step in recognizing.

It's not to say that anyone is bad or is doing anything bad, it's about recognizing that it does exist and it does impact the health of communities, particularly, you know, the African Nova Scotian and the Indigenous community here in Nova Scotia, and addressing strategies that actually combat against and helps to repair the relationships within the healthcare system such as has been done, years of work within the education system as a way of moving forward.

MR. RUSSELL: Okay. Well, I guess with that, Your Honour, I don't have any further questions for the Panel.

THE COURT: All right.

MR. RUSSELL: Thank you for bearing with me this afternoon and this morning. But yes, Your Honour, that would conclude our questions.

(15:50)

THE COURT: Well, I'm going to poll counsel to see if they have any particular questions for any of the Panel members.

Ms. Grant or Ms. Hill?

MS. HILL: Thank you. No questions, Your Honour.

THE COURT: All right, thank you. Mr. Anderson? Ms. Lunn?

MR. ANDERSON: No questions. Thank you.

THE COURT: Mr. Macdonald?

MR. MACDONALD: No questions, Your Honour. Thanks.

THE COURT: Ms. Miller?

MS. MILLER: I have a few questions, Your Honour.

THE COURT: Thank you.

CROSS-EXAMINATION BY MS. MILLER

(15:50)

MS. MILLER: Good afternoon. Thank you all of you, including Ms. MacLean who's had to leave. I echo comments from earlier, I found your report, the fact that it was so collaborative, but also the breadth and depth of it very helpful for us.

My name is Tara Miller and I represent the personal representative of the late Brenda Desmond and I also share representation with my friend, Mr. Macdonald, with respect to Aaliyah Desmond. So Brenda, of course, was Cpl. Desmond's

mother and Aaliyah was Cpl. Desmond's daughter.

I wanted to take the opportunity with your expertise to pull out some more information that could be helpful, at least from my perspective.

Ms. Jordan, I found it really interesting that you worked as a mental health with DND it looks like for about seven years, that's from your resume. That's correct?

MS. JORDAN: Yes, that is correct.

Q. And my question about that is just restricted to one discrete but really important issue I think in terms of mental healthcare and addiction services to Canadian Armed Forces members. Was there any requirement for you as a CAF clinician to have cultural competency mental health training or was that something you just happened to have and brought to the role?

MS. JORDAN: No, there were no requirements, it was something that I had and that I brought to the role. And actually there are no requirements in terms of cultural competency around the members of the African Nova Scotian or Indigenous community that I am aware of or that I was made aware of in my hiring process.

Q. And that was going to be my follow-up question, whether or not you had any awareness of training offered in the

Canadian Armed Forces for a cultural competency for clinicians?

MS. JORDAN: None whatsoever.

Q. My next question, and I'll open it up for all of you, jump in whoever feels they may be able to address this. But this stems from a comment I believe that Ms. MacLean made when she was talking about the significance of Black men in particular showing up in an emergency room and I believe she indicated that that was relevant. That when Black folks present at the emergency room it's because of a crisis. They don't necessarily have the words to explain why they're there and it is in that moment that they absolutely need somebody with cultural competency to help tease that out.

We know from the evidence we've had that Cpl. Desmond attended the emergency room in the Guysborough area and Antigonish area three times within two and a half months: October 24th, December 1st and then of course January 1st.

When we had heard evidence earlier from the clinicians who would have dealt with him, you know, particularly in the October 24th emergency room visit the nurse, Heather Wheaton, indicated that to be there three times in two and a half months was a risk factor in and of itself from a suicide assessment. So that leads me to my question for the three of you in terms of, you

know, is it your view that it is an additional risk factor when doing a suicide assessment to have it be an individual, a Black man, arrive in crisis at the emergency room or it could be an additional risk factor?

MR. WRIGHT: I think certainly that in doing a risk assessment one should certainly have acknowledged race in doing such an assessment as one would also identify gender in doing such an assessment. That we know, for example, that Indigenous folk are dramatically over represented in suicide statistics, that people who are racialized similarly, and that men effect a suicide at dramatically higher rates than women, so these would have been things that should certainly have been factored.

Q. Thank you. And a follow-up question from that. In terms of the risk assessment tools that we've heard evidence that are used throughout the Health Authority, has the Health Association of African Canadians, the group that you're involved in or any other of your groups had any input into the development or informing advice for the development of suicide assessment tools?

MS. DAVIS-MURDOCH: I am, as co-president and founding member, not aware of being asked to participate in that specifically around suicide, no. During my career I was

certainly, you know, on committees as a public servant, but as you know, the Health Association of African Canadians in non-profit, that I helped to found while I was still a public servant, it was not my work as a public servant. So the short answer is no, unfortunately.

Q. So that leads me to ... I'll put a question to you: Do you think it would be a value if there was a cultural competency lens applied to the development of a suicide risk assessment tool moving forward?

MS. DAVIS-MURDOCH: I think you would be able to guess that my answer would be the importance of this perspective in all healthcare delivery, in all service design. Understanding policy development without understanding this component is to not improve, not have effective service for any number of people, not just people of African ancestry but certainly as well for people of African ancestry.

Q. Thank you. And my last series of questions relates to what Ms. MacLean shared with us in terms of specific assistance that was provided to the Guysborough/Upper Big Tracadie community in the aftermath of the tragedy. She shared with us the astute observations of the teacher who identified behaviour that she understood was trauma informed to be able to enlist

some assistance.

So my question is moving forward from ... well, first of all I guess I'll ask and maybe you might not know but if you do, are you aware if there was any further follow-up care that would have been provided to the children in that community after that initial response? Can anyone speak to that?

MS. JORDAN: No, I don't believe there was any additional follow-up. When we returned for the second mental health program or session that we delivered in Guysborough as part of the follow-up we offer folks to be able to call and to reach out for services within that week but, to my knowledge, they did not reach out to myself personally. There may have been calls back to Ms. MacLean but not myself.

Q. Okay. And then my final question and perhaps it's an aspirational one but, you know, we know, of course, from the three generations of family members who died in this tragedy left behind a legacy of trauma for their family members: Cpl. Desmond's siblings, his nieces and nephews.

We heard from one of ... my client during her family evidence, she has her own PTSD diagnosis as a result of this tragedy, and certainly there, I would expect, are other mental health impacts on other family members. Brenda's children and

grandchildren were left behind, Aaliyah's aunts and cousins. Shanna's siblings and parents.

What would you prescribe, if you could, and I guess I understand that this is perhaps aspirational but leaving aside resources, but what would you be prescribing for the surviving family members in the aftermath of this deep trauma on top of, you know, a history that we all now know, what would you be prescribing for their own mental health recovery at this point?

MS. JORDAN: Did you want me to go first, Robert, or would you like to go first?

MR. WRIGHT: You can go first, I'll follow up.

(16:00)

MS. JORDAN: As a mental health nurse, what I would prescribe, and as a member of the African Nova Scotian community, I would prescribe culturally responsive trauma treatment ongoing for members of the family, members of the community. And that treatment would look like anywhere from psychoeducation, bringing awareness to the emotions, giving some literacy and some language to some of the feelings and the responses that they're having.

I would also recommend process groups to be able to process some of those feelings and emotions. I think that oftentimes we

run into issues around maladaptive or ineffective coping skills when we're not able to process emotions. And, again, this treatment service would have to be culturally relative for the individuals.

Yes, so that's certainly where I would go with this in terms of like, you know, at different stages for different populations, there's, you know, younger folks. Children, adolescents, adults, and seniors that were impacted as a result of this. So I think that the treatment services would have to be altered in a way that would provide services across the lifespan for those individuals.

MR. WRIGHT: Just in terms of following up and supporting that, I would say that, of course, in the wake of a tragedy, we can think of the services that should be made available to this particular family. But I think that I would go further to say that the sorts of things that Ms. Jordan speaks about are things that should be available in communities so that long before these sorts of tragedies happen, these sorts of resources are available. We know that Black people suffer from multi-generational trauma. We know that Black people suffer from isolation, from poverty, from lack of education. We know these things. We know that the mental health impact of these systemic

influences that we would only make these things available to Black families intergenerationally after a tragedy is perhaps indicative of how we find ourselves here.

And what I would say is that this work needs to be done in a community-based mental health models with multi-disciplinary service delivery teams. When Ms. Jordan talks about process groups, what she's saying is that this kind of mental health service delivery is not just one-on-one counselling. It is about community facilitation. It is about process groups. It's about family interventions. It's about multi-generational service delivery. It's about public education. It's about, you know, all of these kinds of supports and resources that should be available. And if that sounds like a rich and too rich a kind of panoply of services, we only need to recognize the amount of resources we spend after such tragedies, you know, so ...

MS. MILLER: Thank you. Unless someone else wants to offer some further insight on that, those are my questions. I appreciate your time today. Thank you all.

THE COURT: Thank you, Ms. Miller. Mr. Rogers?

CROSS-EXAMINATION BY MR. ROGERS

(16:04)

MR. ROGERS: Good afternoon. I am Rory Rogers. I am one of the counsel for Nova Scotia Health. I want to thank you for your time and your insights to this Inquiry. I just have a few questions and I probably would have directed them towards Ms. MacLean but I know she had to leave a little earlier so I will direct them to you and there is one area that I want to cover.

There were comments with respect to an excerpt of the report that I believe came from a comment and, in turn, that came out of the Mental Health 101 sessions in Guysborough County. And the reference is in that report, and it was part of a question that Mr. Russell put to the Panel and Ms. MacLean addressed, and it dealt with the question of staffing at the local hospitals, including St. Martha's, and whether the preference would be to get a drive to go to Sydney. And given it's a public inquiry, it's being broadcast and there is wide public access to this, the concern I have is that somebody might take that view that apparently is coming from one participant in the Guysborough County proceedings and have a misapprehension as to the nature of the services that, in fact, are available at St. Martha's. And the concern I have is that that would drive

somebody to make the much longer drive to Cape Breton Regional when services are available at St. Martha's. So I would like to break that down in part.

There was reference in Ms. MacLean's comments earlier this afternoon to the fact that it was a participant at that Guysborough County session that said that in Sydney there are mental health crisis teams available.

Now this Inquiry has heard evidence that when individuals attend at emergency department at St. Martha's there is, in fact, a mental health and addictions crisis team available, persons with mental health nurse training such as I think you would likely have, Ms. Jordan. You are not disputing that there is mental health and addictions services available through the emergency department at St. Martha's, are you?

MS. JORDAN: No, I'm not disputing that.

Q. And, in fact, the Inquiry has heard evidence that Cpl. Desmond did access and receive those services on October 24th. And then the Inquiry has also heard evidence that at the time of Cpl. Desmond's attendance late in the evening of January the 1st and into January the 2nd of 2017, at that time, he had access to services by way of an emergency physician as well as a psychiatrist. So he's arriving in the late hours and he's

getting access to a psychiatrist who provides him services. So, again, I would assume you are not disputing that those level of services are available at St. Martha's Regional Hospital? Is that a fair comment?

MS. JORDAN: That is a fair comment.

Q. And, again, the reason I want to emphasize that is I don't want anybody to be taking this information that's come secondhand before the Inquiry and think that St. Martha's is not a full service regional hospital providing all those services, including mental health and addiction services. Is that a fair concern on my part and is that something that you believe to be correct?

MS. JORDAN: Absolutely. And I think that, you know, in terms of the report, that's the report of one individual, one perception of an individual, not a collective.

Q. Okay, thanks. Those are my comments.

THE COURT: And I think as well ...

MR. WRIGHT: It I could just ...

THE COURT: Sir, I think as well, I mean that was commentary from, I think 2017, 2018? This is 2021 and so the applicability of that observation of that individual may no longer have a lot of impact value for us today.

MR. ROGERS: Understood.

THE COURT: Sorry, Mr. Wright, you were going to add?

MR. WRIGHT: I would just say something about mental health and addiction service delivery. I think that, and again, the point is well taken that the comments of an individual should not suggest that certain services do or do not exist. It's about a perception and about the capacity that is perceived by members of a certain community relative to those systems.

I'm, for example, intimately familiar with the network of meetings that are available in AA, for example, which is probably one of the most powerful community-based interventions relative for addictions. However, the AA model does not well serve people of African descent, for a number of reasons that I won't get into here. So if a Black person says, Aah, I don't find, you know, you shouldn't go to AA, that's not to disparage AA as an organization, generally, but to say that there is something that's happening there that doesn't meet the needs of people of African descent.

MR. ROGERS: It would be fair to say as well, Mr. Wright, that there always can be improvements in terms of information being provided to the public in terms of the mental health services that are available?

MS. JORDAN: Absolutely. Absolutely.

MR. WRIGHT: Yes, there certainly could be improvements. Not just improvements in communicating to the public what is available but improvements in the capacity of the system to be responsive to African Nova Scotians. And that is not about public relations, that's about substantive capacity.

(16:10)

MR. ROGERS: Thank you.

THE COURT: Thank you, Mr. Rogers. Mr. Adam Rodgers?

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

MR. RODGERS: Good afternoon everyone, I am Adam Rodgers and I am counsel to the personal representative to the late Cpl. Lionel Desmond and I have some questions for you as well. First, I just wanted to start off by saying I certainly echoed some of the comments that I appreciate your input and I know that my client and the family appreciates your input as well, the report that you've prepared, and the testimony. It has been quite valuable and very insightful, I think, for everybody.

I wanted to actually also draw some attention to the model

of the organization that's on your letterhead "Our Health is Our Wealth". And I thought that was quite appropriate and well chosen as a model for the organization. It's certainly appropriate.

I have a few areas I wanted to cover with you and one is just the community history and talk a little bit about the effect of that history on current opportunities and barriers. Ms. Jordan, particularly, spoke about the origins of Lincolnville/Upper Big Tracadie/Sunnyville areas. These are settled by Black Loyalists on some of the worst land that they were given in the area, far from the water, not great soil for farming, elevated land. In your experience, or I guess with your knowledge of communities throughout Nova Scotia, would you say that that is uncommon or common throughout Nova Scotia history that that's been the case?

MR. WRIGHT: Yes, that has been common for people of African descent to be settled on such land.

MS. JORDAN: And, in addition to settled on such lands, settled near undesirable landfill sites as well.

Q. That's certainly the case with the Lincolnville/Upper Big Tracadie area, right next to the waste management facility there.

MS. JORDAN: Absolutely.

Q. In the report, you talk about the military being seen as, particularly for young Black men, as a way out of the community and it's significant that a way out is something that is needed or seen to be needed in that context. I guess you would agree with that.

I want to ask, perhaps particularly Ms. Jordan, I think you have met Lionel at least and maybe known him a little bit. Would you see how the socioeconomic circumstances, the desire to improve your economic lot would lead someone perhaps, who would not otherwise be inclined to combat, to join the military as a way to further themselves and their family?

MS. JORDAN: Absolutely. And it's actually quite common in the community of Lincolnville, they have had a number of individuals who have enlisted. You know, it's no secret that the military offers a level of employment and financial security that doesn't necessarily exist for a lot of young Black people and, particularly, young Black people, young Black men from small Black communities. So the military is definitely and has definitely been something that ... or a way out of poverty for folks from small Black communities. I think about a number of individuals who have enlisted and joined and who have returned,

being service members in my community of Lincolnville, absolutely.

Q. So in addition to the conditions of poverty that certainly exist in the family you've heard of the home being a multi generational home, economic employment opportunity is limited that there was a lack of community navigation into conventional mental health and addictions programs available within the community.

MS. JORDAN: Absolutely. It doesn't exist. It doesn't exist.

Q. And transportation to facilities or to providers also an ongoing issue. I know that there is a group that is trying to address transportation in these particular communities but that has historically been an issue as well, would you agree?

MS. JORDAN: Yes, to all resources, transportation is an issue for health, for education and for, you know, general needs within a household. It's very expensive and unaccessible for a lot of folks to travel outside of the community.

Q. Another issue that was identified in the report was mental health literacy and that, for the most part, unless somebody is charged with a crime and is ordered into counselling, that mental health treatment is not generally

considered by outside providers, certainly, is not considered a common or certainly a first avenue to seek help.

MS. JORDAN: Absolutely not. You are correct.

Q. Another issue I wanted to ask about, and it is listed on page four of the report and the comment is that there's an ongoing frustration with experiencing microaggressions and systemic barriers to health education and employment often manifests in unhealthy coping mechanisms. So that the microaggression within the treatment provider, I guess atmosphere, that potential for microaggressions, I guess instead of overt racism, as there may have been in the past, now it's microaggression. I'm not sure how that, if that transition from the overt to the microaggression has developed but it's certainly a present factor for any African Nova Scotian person seeking treatment.

MS. JORDAN: Absolutely.

MR. WRIGHT: And any African Nova Scotia working within the systems as well.

Q. I suspect you could tell us a lot about microaggressions and how those manifest themselves in circumstances but presuming ... Well, maybe I'll let you speak to that for a moment and I have a question arising from it, if

you would like to, Mr. Wright.

MR. WRIGHT: In terms ...

Q. What we should know about microaggressions, yes.

MR. WRIGHT: Well, I'd say a microaggression is kind of a comment or a gesture and an action that is regarded these days as a subtle or unintentional discriminatory act that is directed at a person from a marginalized group that is kind of, what I would say presses one of the pressure areas or the sensitive areas of that group. So, for example, if a person speaks with a slight accent and a person simply says, Oh, where are you from? That simple gesture, given the context, others that person and essentially points out that they are not one of us. Or you might say to a Black person who says that they just renewed their mortgage, you might say something like, Oh, you have a mortgage? Which is, again, saying subtly, Well, I did not think that you, as a Black person, would actually own a house, how did you get a mortgage? So these are the kind of microaggressions that are kind of everywhere that marginalized and racialized people live with.

MS. JORDAN: Yeah, and another example, quite simply, of a microaggression would be, say, for instance, if I'm standing at a counter and you're standing at a counter, sir, and I was

there first and the service person serves you first and disregards me as an individual standing there, that's a microaggression. You know, touching one's hair, you know, let me see, let me feel your hair. Oh, let me touch those braids. Or, you know, those sorts of things are microaggressions, are simply not seen as harmful by white folks but are extremely harmful and send a different message to a racialized person.

(16:20)

MS. DAVIS-MURDOCH: And I'll just add one which I know has been experienced by my colleagues with this meeting and that is when you work in the system, and I worked as a public servant, trying to put forward progressive policy options or having a discussion about things like that and being said, well, or being ... that there would be comments around the table like, Well, I mean, you know, we don't want them to play the race card. That is a very common occurrence that that is said and that those of us who are working for social justice, it is very grating and it's disrespectful of what our intention is and of what the intention of the people that we are representing or that we are discussing. In some cases, it's just about discussing them. You know, that is not what is happening. What is happening is that they're seeking equitable care, equitable service,

improvements, and yet they are categorized as playing the race card. That is a very common and debilitating microaggression.

Q. It strikes me that when this is a barrier to care. Because as soon as you would consider getting treatment, the first thing you know is that it's going to be a little bit worse before you get treated because you're going to be facing potential microaggressions as you go into the treatment provider's office or into the hospital or wherever that treatment may be provided.

MS. JORDAN: Absolutely. And if I could just add, like sometimes it's not even what folks say, it's the feeling, the energy that's given off. One thing that Black people are very good at is picking up on emotional vibes. We've actually survived by being able to pick up who are the safe people and who are not the safe people. So we are energy folks and we pick up on that energy. So sometimes it's not in what people say, it's the way in which the body language. We read all of that stuff because we've had to maintain safety over centuries, over centuries by picking up on energy. And so I just can't reiterate that enough. Sometimes people say, you know, I provide a nonjudgmental service. They may have nonjudgmental in their head but their past experiences in their lens don't

necessarily match and Black people will pick up on that when we've experienced racism over a lifespan. So those are actual microaggressions in terms of body language and not necessarily in words.

Q. Just thinking of again the community capacity. You've talked about care providers and, you know, there's just not enough clinicians of African Nova Scotians descent in the system. More need to be in the system, certainly in the Antigonish/Guysborough area. And that's sort of a particular impact of the rural Nova Scotia situation. And it puts some pressure on the community resources and one of those, in particular, seems to be experiencing its own problems and that would be the Baptist Church. Throughout your report, it seems to be a focus of, you know, the volunteers, you know, mental health counselling that comes through the church, the support mechanisms within the community throughout the church, and it seems to be a prominent feature, I mean not only, and of your organization as well. But then the church itself seems to be experiencing, you know, not cutbacks but there's not a permanent pastor in the community, it's rotational. So that steady presence isn't what it may have been, you know, even 10 or 20 years ago. Is that a factor that you're seeing developing in

these communities?

MR. WRIGHT: We are certainly seeing that. Certainly with the out migration of people of African descent and the dispossession or the disintegration of Black communities, the supports and the resources that were enabling churches to be the centre of community in that way, are being stressed, particularly in rural Nova Scotia.

MS. JORDAN: And if I just may add just for a moment, in terms of the services that are provided within the African Nova Scotian churches, that spiritual health oftentimes, they're not actually licensed clinicians that have the skillset to be able to do meaningful work in terms of psychotherapy. So that is, you know, oftentimes we rely in folks who have strong spirituality within their lives can cope, but not necessarily have all aspects of an area to really to thrive. It may help them survive but not thrive in terms of mental health.

Q. And I wanted to ask you about that maybe, in particular, Ms. Jordan, because with your experience dealing with members of the Armed Forces, you may see the complexities of their conditions may just be too much for, you know, a spiritual guide from a Baptist Church or any church to handle in the first place. Is that something that, in your experience,

you would be able to make a comment on?

MS. JORDAN: Absolutely. We just don't have the skillset. We don't have the resources, the infrastructure within the African United Baptist Church to provide that. We often go in and we can access individuals under the African United Baptist Association umbrella of individuals but this is, again, volunteer work, which we often step to the plate to do this type of work, which is taxing on the clinicians, the individuals themselves. Oftentimes, we're not supported in the work that we do in the organizations that we do to respond to community services under the capacity of the umbrella of the health authorities.

Q. And then taking that a little further, and I see in your recommendations, you know, that you're suggesting this ... you're not suggesting that this be cycled in any way through the church structure but, you know, in these particular communities, there's not just Baptist, there's Catholic and there's Jehovah Witness faiths as well, and the faith door itself may be a barrier for some people and maybe particularly the young people that need to access services. So would you agree, I guess, that it would be best if it's a nondenominational or a non faith-based organizations that's really at the core in providing these

mental health services?

MS. JORDAN: Absolutely.

Q. Just a couple more questions but it struck me about how ... it talked about how it's, you know, when you're dealing with caregivers that there's some suspicion. And we've heard from the caregivers through the Ste. Anne's Clinic in Montreal where Cpl. Desmond spent three months that when he left there, he had some suspicions about their intentions. When they spoke French around him he thought, you know, maybe they were talking about him, maybe they were saying bad things about him. I guess that's consistent with what you were saying earlier about potential suspicions of caregivers and that's a barrier as well to services?

MS. JORDAN: I would say that what I would draw from that is that it builds on the argument of lack of trust within the health organizations.

Q. Now the ideal perhaps long-term solution is that there are more African Nova Scotian clinicians, people available to be at least consulted in these situations. In the meantime or in situations like Ste. Anne's where, you know, maybe the services are so specialized that there's only a few that are providing, is there another way to build that trust either through, you

know, other patients that had been through the service themselves? You know, other, you know, mentorship situations. Is there other ways to build that trust, you know, other than the clinician being in the community for many, many years or some other long- term situation?

(16:30)

MR. WRIGHT: Again, I would say that the system has to build competence in serving populations and that building that competence is how you build the confidence. And you build that confidence competence by having the service providers who are present learn how better to serve the community, building partnerships within the community and having, as we said, specialists, clinicians who are people of African descent visiting regularly to bridge that gap between community and local service providers. So there is a way to do that over time.

Q. One of the last things I noticed, of course, is the hesitancy to seek services. Now we know that eventually Cpl. Desmond did seek services and he sought them fairly regularly and persistently, to his credit. But it was four years after his deployment, which was in 2007. It wasn't until 2011 that he really started accessing services regularly. Is it possible

that's a manifestation of what we've been talking about in terms of, you know, the resistance to accessing those services in the first place?

MS. JORDAN: I think the stigma is there for anyone with PTSD and the resistance to come into services, to be assessed, and to be treated for such. The stigma still exists and is still very strong. And I would say that being a Black man seeking services for PTSD or for trauma, in general, would be even more difficult to admit that, you know, I am struggling.

Q. And it was four years, and we've heard from other psychiatrists, psychologists, that it's very important, particularly with PTSD, that this trauma be addressed as soon as possible and be done immediately. And so for a Black man, in particular, if there's these systemic hesitancies to access the services, yet those services for this particular condition need to be accessed sooner rather than later, that there's really a disproportionate effect when it comes to PTSD on soldiers of African descent. Would that be a fair conclusion, do you think?

MR. WRIGHT: A compounding effect. This is what we call intersectionality, right. That there are layers of effect that he is not only a person who is a service member who has experienced trauma, he's also a member of the African Nova

Scotian community. And so, in that intersection, there is a compounding effect of trauma.

Q. So that was four years post deployment, and then for the following five or six years as he was being treated, not once did he see a clinician of African descent. So can you comment on the significance of that over the course of his fairly extensive treatment?

MR. WRIGHT: Well, I guess I would say that, again, going back to the DSM, the **Diagnostic Statistical Manual** says that cultural formulation should form a foundation of any good mental health assessment and that even if a person was not able to access a Black clinician, they should certainly have had clinicians who were able to do such an assessment or clinicians who could have recognized the need for such an assessment who could have consulted with a Black clinician to do so. That that did not happen just, as I said before, speaks to where we are currently in mental health service delivery and understanding these things.

MR. RODGERS: Thank you for that answer and, again, thank you all for your testimony, for your report and insight into all of these matters. Those are all the questions I have, Your Honour, thank you.

THE COURT: Thank you, Mr. Rodgers. Mr. Russell, is there anything further?

MR. RUSSELL: Nothing, Your Honour.

THE COURT: Thank you.

It would appear that those are the questions for the day. I know it's been a long day. I would like to thank you all for your time, as I did Ms. MacLean. I think it was of great value, Ms. Davis-Murdoch, for you to have made the application on behalf of the Health Association of African Canadians, and to bring along Mr. Wright, Ms. MacLean, and Ms. Jordan. And I know that when we first had our discussion, I was a little, I don't know if I would use the word reluctant, but the format that we wound up using that had been suggested early on, I was a bit hesitant because it's different and I guess sometimes going out on a limb to look at something differently is unsettling but I think that you've shown to me that there is great value in looking at a format, particularly when you can bring a collective together of individuals, who clearly work well together, and it kind of opens, I think, the way for this kind of evidence and other inquiries. I think it's of great value. The interplay amongst your expertise is of great value to me and I think to the others that have been here today and listening

and, hopefully, for those that are listening beyond this courtroom as well.

Once again, we very much, I certainly very much appreciate your time and your effort to be here today. Mr. Wright?

MR. WRIGHT: Your Honour, not to steal the last word, but if I could simply say that your willingness to step out of the usual to trust Ms. Davis-Murdoch, who is an expert, clearly, in health policy and as that relates to people of African descent, your willingness to step out of the usual to consider something a little different in order to consider this important evidence about the racial context of this tragedy is indicative of how a system must respond if a system is going to be culturally competent.

So I want to credit you with your willingness to step outside of what is the usual in hearing this piece of evidence that I believe will be very critical.

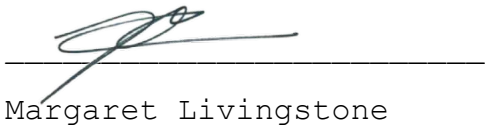
THE COURT: Thank you for the vote of confidence, Mr. Wright, I appreciate it. Again, thank you for your time and we will adjourn for the day. Stay well, folks, thank you.

WITNESSES WITHDREW (16:38 hrs.)

COURT CLOSED (16:39 hrs.)

CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.



Margaret Livingstone

(Registration No. 2006-16)

Verbatim Inc.

DARTMOUTH, NOVA SCOTIA

December 13, 2021