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: September 15, 2021

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EXHIBIT LIST

September 15, 2021

COURT OPENED (09:33 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Murray, I understand you have a witness for us this morning?

MR. MURRAY: Yes, Your Honour. We're calling Nancy MacDonald.

THE COURT: All right, thank you.

Ms. MacDonald, could you come forward, please? If you just turn to your right and walk along that railing ...

MS. MACDONALD: Of course.

THE COURT: ... it will eventually bring you over to the witness stand ...

MS. MACDONALD: Great.

THE COURT: ... just to my left here. Thank you.

NANCY MACDONALD, sworn, testified:

THE COURT: I was just going to give you the option, Ms. MacDonald, of removing your mask if you were comfortable removing it.

MS. MACDONALD: Oh sorry.

THE COURT: No, that's fine. You just anticipated what I was going to tell you, at any rate, but you've removed your mask; I take it you're comfortable with your mask removed. This room is set up in such a way as to be COVID compliant, at least by the current rules. Thank you.

Mr. Murray?

DIRECT EXAMINATION

(09:35)

MR. MURRAY: Thank you, Your Honour.

A. Good morning, Ms. MacDonald.

Q. How are you?

A. Good, how are you doing?

Q. Good, thanks. Can you tell the Inquiry your name, please?

A. Sure. My name is Nancy MacDonald.

Q. Okay. And you're an M-A-C MacDonald, are you?

A. I am an M-A-C MacDonald, yes.

Q. All right. And, Ms. MacDonald, what do you do?

A. Sure. I am Executive Director of Family Service of Eastern Nova Scotia.

Q. Okay. And how long have you been Executive Director of Family Services (sic) of Eastern Nova Scotia?

A. In preparation for this, I actually had to look back and find out. Twelve years I've been Executive Director. I've been employed with the agencies for 24 years, though.

Q. Okay. Twenty-four years with Family Services?

A. Yes.

Q. Okay.

A. Yes.

Q. And Family Services of Eastern Nova Scotia, your physical location - I guess your physical location is in Antigonish, is it?

A. Yes. Pre-pandemic, I'd like to say my physical location was my car. Because we have a huge geographical region, I spend most of my time traveling around amongst offices. So we have various offices in various locations but, yeah, most of the time you could find me in Antigonish.

Q. Okay. And your education, your training, what is your

background?

A. Sure. Originally, I was a teacher and then I now have a - well, a long time ago - I have a Masters of Education in Counseling. So kind of therapy is my core work. That's how I was first hired with Family Service.

Q. Okay. So are a registered therapist?

A. Yes.

Q. Okay.

A. Yes.

Q. Am I using the right terminology?

A. Yes, yeah, that's fine.

Q. Okay. And that's how you came to be involved with Family Services, was it?

A. Yes. I was actually hired ... my first four years with the organization was in Guysborough and I provided Counseling and therapy to families in and amongst Guysborough County - Guysborough and Canso.

Q. Okay. So I wonder if you could tell us a little bit about what Family Services of Eastern Nova Scotia, what you do and what services you provide to the general public.

A. Sure. Our organization is a registered not for profit and we're 52-years old and we're governed by a volunteer board

of directors. In the past two years, we've experienced significant growth, so our name hasn't quite caught up with the growth. Our name is still "Eastern Nova Scotia", which represents our history. We were New Glasgow to Cape Breton which was where the regions that we were provided funding to provide service to. And now we are provincial, so we have programs that run across the province, which is fantastic - and we can talk about that a little bit later - but the core work of our organization is Counseling and programming; and by programming I mean group therapy and psychoeducational programming.

And the philosophy is family-centred work. We have, predominantly, about probably 85 percent of our staff are social workers or registered counsellors. And then we have a few paraprofessionals who do other programs such as supervise access and exchange, but the majority of our programs are to place social workers or counsellors in collaborative practice sites across the province. So we have social workers in schools, we have them in First Nations health centres, we have them in our own offices, and the core work in our own offices are individual couple and family Counseling. That's kind of the history of the organization is that work.

Q. Right.

A. The growth has come beyond that but ...

Q. Okay. So I want to ask you about a couple of things there.

A. Yeah, okay.

Q. So the name of the organization is "Eastern Nova Scotia".

A. Yeah.

Q. But you said you've grown from there; so, originally, Family Services was just in the eastern part of the province?

A. Originally, it was in New Glasgow east. So we have core offices in New Glasgow, Antigonish, Port Hawkesbury, Glace Bay, and Sydney. And so we're in the process of a name change; it's just the Joint Registry of Stocks is a long process.

Q. Oh okay, fair enough.

A. Yeah.

Q. What is it going to be changed to?

A. Well, that's partly what we're still trying to decide in conversations with them, yes.

Q. Okay. So your organization has been around in one form or another for over 50 years.

A. It has.

Q. Okay.

A. Mm-hmm.

Q. There are other family services organizations in other parts of the province now?

A. There are and in the rest of Canada. There are over 300 family service agencies across Canada and, in our province, there's ourselves and Family Service of Western Nova Scotia - those are the two - and we have a network within Atlantic Canada. There are two in New Brunswick, there's one in PEI.

(09:40)

Q. Okay.

A. Yeah.

Q. So Family Services of Western Nova Scotia, what areas do they cover or serve?

A. The South Shore, predominantly. So they're based in Bridgewater and they do Bridgewater, Liverpool, Lunenburg - that area.

Q. Are you coordinated with them in some way?

A. We are. Mm-hmm, we are. We work really closely with them. Some of what I'm hoping we'll talk too about today is some of the work that we've been doing and the leadership our organizations have been providing around the work around trauma

work. And that's been with that organization.

Q. Okay. And the philosophy or the approach of the various family services organizations; say, around Atlantic Canada or even across Canada, is it similar?

A. It is. That core foundation is accessible care, no cost or minimal cost, and never turning anybody away based on inability to pay. And, really, that family-centred/person-centred work is really the core part of what family service agencies do. When you look across Canada, they range in size from tiny little ones such as, Family Service of Western is relatively tiny compared to Family Service of Vancouver which is a, you know, $22-million not for profit. So they really range in size, but the core work is community-based really sound mental health work with families.

Q. So you said that you did some work in Guysborough as well.

A. I did myself, yes.

Q. You did, okay. You don't have an office in Guysborough?

A. No. We used to. We used to share an office with the school and, back in my day, that was, you know, in the early '90s, we used the courtroom in Canso was where I used to see

families sometimes.

Often, due to funding, we will share space in communities. We often don't have offices ourselves. We have those core physical locations like I mentioned in Glace Bay and Sydney and Antigonish - the bricks and mortar, which helps support the foundation of the organization, but for almost all the rest of the work, including all our new work in Central and about to be in Kentville, we don't have bricks and mortar; we share spaces. And, in Port Hawkesbury, we have a shared space at the Provincial Building.

Q. Okay. So you do do outreach into other communities ...

A. A hundred percent, yes, yes.

Q. ... beyond just where your physical core offices are?

A. Absolutely. We learned a long time ago that you can't ... that there's a need for the bricks and mortar and there's a need for space for people to be able to come to you, but there's just as much of a need for our workers to be able to go to people. Especially, we provide service to rural ... Nova Scotia is predominantly a rural province and the populations are everywhere, and so it's important that we have workers other places.

Q. So you were saying it is important to go to people whom it may need or make yourself accessible in rural areas to people who need Counseling?

A. It is. And I think another underlying philosophy of the not-for-profit world, and particularly our family-serving agencies, is a willingness to continue to transform and step into gaps. And when I say that, I mean the government systems. We need government systems, but government systems are large and, due to the nature of their structure, they tend to be a bit siloed. And so the beautiful thing about not for profits and community-based organizations is we're smaller and we're more flexible and we can be quite reflective. And so we step into gaps. And so the whole work in Guysborough early on in my career was identified as a gap that community spoke to Department of Community Services and said, We need access to services. Department of Community Services phoned - I was an ED at the time, obviously - and said, Listen, do you have a staff member that can start to provide service in that community if we figure out space and everything else?

So that's been our whole growth of our organization is figuring out, based on the community's needs, what are the gaps and how are we going to step into those gaps?

Q. Do you continue to provide service to Guysborough?

A. Not physically, but remotely. Yeah. So the pandemic obviously has changed a lot for the better and we never missed a day of work during the pandemic. We mobilized into virtual care immediately. And the beautiful thing about the virtual care is it's given safety and choice and control to the process for many families. And so not everyone wants to come in physically to an office space - the bricks and mortar. There's various reasons about shame and then there's poverty, concerns about the cost of transportation and gas. And so the fact that we now provide telephone and Zoom-based or face-to-face Counseling has been quite helpful to increasing the access. We've seen quite a phenomenal increase in access of our services since the pandemic.

Q. Okay. So the telehealth, or telecounseling is the right term ...

A. Yes, yeah.

Q. ... but telephone Counseling and virtual counselings and whatever, did the growth of that come exclusively with the pandemic or was that something that was slowly evolving before the pandemic?

A. It's been slowly evolving. I always say, as an

organization, we're tiny but mighty, and so when I say ... We're a large not for profit in comparison to many others in the province, but small in terms of we're a staff of about 55 and we probably have touch points of over 10,000 in the course of a year in terms of contacts with families or individuals or couples. The amount of work that we're engaged in is quite profound, and so we always have more requests for service; particularly around the therapeutic services program. We have more requests for service than we can keep up with.

Q. You used a word there "touch points"?

A. Yes. So I mean, when I talk about touch points, we, as an organization, are very, very aware that, as professionals, we should not decide on who is the most important person that comes in contact with an individual. And when I say that, I mean we've come through a place with our trauma work that the therapists - and I was one of them and I'll get to that in a second - we used to think that the most important touch points were with us, that what happened behind the closed door in the therapy room was the golden nugget of that work.

But through the years and through the work and through the conversations with our clients, we've realized that the welcome from our admin, the smile from the admin, the tone of voice from

the admin, the feeling in our environment, that was just as important of, in terms of the client's care or the family's care as was what we thought was the magic behind the closed door.

So we're trying to pay a lot more attention to the importance of every single touchpoint across our organization. As soon as somebody comes in contact with our organization, we want it to feel a certain way.

Q. Okay. So it's important to create a welcoming environment.

A. A hundred percent.

Q. Okay. And a touchpoint then is when any member of the public comes in contact with any member of your staff, is it?

A. Yeah. We don't get to decide if a phone call with an admin is important or not important. The fact that an individual is calling and talks to an admin, we have no idea whether that's the only touchpoint we're going to have with that individual and we need to make that touchpoint as meaningful as possible. We used to think, okay, well, you know, the important stuff happens with the therapy. Not necessarily. We've learned a lot from ... when I think back to some of the other work with schools and you would be talking to kids and we, as professionals, like I said, teachers, and we like to think that

we are the main points of support. And kids will often report that the janitors and the support staff in the school are their key supporters. They're the ones who greet them in the mornings, they're the ones who are always there in the hallways when they are experiencing rough patches. And so when I've done lots of trauma work across the province and across Atlantic Canada, I always am trying to encourage organizations to implement trauma, inform principals vertically down. Don't elevate anyone, any person's importance, more than anybody else in the organization. Have everybody as fully aware that their touchpoints could be the most meaningful in that person's life in the day.

Q. Okay. Now you said just a couple of things about the mechanics of your organization. You said you have 55 employees?

A. Yeah, about that, yeah.

Q. Can you break that down a little bit for us with how many therapists and counsellors or who do you employ?

A. Sure. Our organization runs about 27 different programs and we have well over ten funding sources. And the funding sources are important because they kind of link to the collaboration, but we have funding partnerships with First Nations communities, and with Department of Education, and

Department of Community Services. And so those people, those 55, are spread out amongst programs. So, for example, in Cape Breton, we staff the SchoolsPlus social workers, and so there's 13 of those. And then we help staff the family-centred work in Wagmatcook First Nations Community, and so we have three staff in that community.

So, like I said, the majority of those 55, probably 50 of those are actual social workers or registered counsellors and the other ones would be part-time and be doing supervised access and exchange, which is a relatively new program for us, funded through Department of Justice.

(09:50)

Q. Okay, but 50 actually ...

A. About that.

Q. ... roughly, of your employees are actually registered either social workers or registered counsellors?

A. Yeah. It kind of makes us who we are.

Q. Okay.

A. Yeah.

Q. And then you have some administrative staff, obviously, as well.

A. Yes, yeah.

Q. Now you talked about your funding sources.

A. Mmm.

Q. And you said you're a not-for-profit organization.

A. We are.

Q. Okay. And to run all those programs and keep all those people employed, you obviously need funding.

A. We do.

Q. That's no doubt an ongoing challenge.

A. It is.

Q. A not for profit. Where does your funding come from?

A. It comes from various sources. I would like to say one of our primary partners in this work is Department of Community Services. It's been a historical partner. And I use the word "partner" because we've worked really hard at and been a part of their transformation. That government department has been involved in really quite profound transformation for well over three or four years, and part of that transformation has been to lean into community-based organizations to assist them in actually doing their frontline work. So they hold, you know, the important pieces that they can't give to anybody else, like Child Protection and Income Assistance, and then they actually, especially through the Prevention Early Intervention, the Child,

Youth, and Family Division, all of that work is then funded into frontline ... our community-based organization.

So as a frontline ... as a community-based organization, we run a program called "Families-Plus" which is an intensive home-based program that we have two social workers in a home at a time and they're actually doing the work with the families in the home. That came out of a lot of conversations and a lot of collaboration with Child Protection around - Wouldn't it be nice if we could get, when those families are at that critical stage of running the risk of losing their kids into care, what if we actually had social workers that could go into the homes and mitigate some of those and create safety and begin to actually do some really profound intensive work.

And so that program came. We're running that program almost across the whole province. There's a lot of need for growth in that program because ...

Q. Sorry, that program is called?

A. It's called "Families-Plus".

Q. "Families-Plus".

A. And that's funded exclusively through Department of Community Services.

Q. So the various programs that you run, you get funding

for the programs.

A. We do.

Q. Is that how it works?

A. We do.

Q. You don't a core funding for your organization?

A. No. No. Part of our sustainability and our visioning and our growth comes from the fact that we sit quite well amongst the work of various government departments. The core work is kind of the mental health of families and how are we going to improve that and enhance that? But lots of government departments are interested in that.

So DCS has used us, Department of Justice is leaning in on us with supervised access and exchange, Department of Ed through the SchoolsPlus. So we're just in this interesting ... I don't think that we could be who we were if we were solely funded by one shop. I don't think that would work as well.

Q. Okay. So you've mentioned DCS, you've mentioned Justice, Education. So various government departments funding particular programs will come to you.

A. Exactly, and say, Is this a possibility? And, for us, it's about are we willing ... is that government department interested and willing to engage in transformation and truly see

us as a collaborative partner? We have a lot of knowledge based on community and so the most beautiful work, especially with DCS, has happened because we're just an active partner in that development of those programs too.

Q. So when they come to you with a program, I'm just curious about the process.

A. Yeah.

Q. Do they come to you with a general idea and say, Work with us in developing it? Or do they come to you with a program fully formed and say, Here you go; implement this.

A. Both.

Q. Okay.

A. Both. Typically more as they're farther in their transformation - and I'll speak mostly about DCS because that's where our biggest growth has happened in the last couple of years - it's really about - Here's an idea. Here's something that we're struggling with. Here's something that our other community-based organizations are seeing. And can we come up with or can we see what we can create together?

Q. Okay.

A. Yeah.

Q. You are a not for profit.

A. Mm-hmm.

Q. Do you have other sources apart from government?

A. We do. We have private donations, we have, yeah, we have a lot of ... what we've started to lean in on, which has helped us immensely, is some social enterprise contracts; and, by that, I mean that we have for profit ability to place workers in various settings and then anything that's earned over and above for that, we're then able to funnel back into the core work.

Like I said, we always have more clients trying to access our therapeutic supports than we have the manpower to service; but, more importantly, more than 80 percent of our clients that are asking for service don't have the ability to pay. And so because our mission is to never turn anybody away, we needed to create, other than continuing to ask government for money, we needed to create a viable solution that we would be able to continue to provide service. And so some of our social enterprise contracts allow us to do that.

Q. Okay. And do you ever charge clients?

A. Yeah. If they have an ability, that's all part of the first call intervention. There's a conversation with the social worker and there are, like I said, not very many. There's only

about 20 percent or less than that. If they have the ability to pay, then they do pay. It's a sliding scale. It could be as small as $5 and it could go up to as high as, I think it's 65 or $70. The highest, at the far end, the 65 to $75 paying clients are very, very few and far between for us. Most of the time, when somebody is calling, there is an immense need in their families, and often financial constraints or financial issues are part of that, so they can't pay.

Q. Okay. All right. So the nature of the work primarily seems to be Counseling and therapy with clients.

A. Yeah.

Q. And assisting clients with those types of issues. What types of Counseling or therapy do you provide? Is it purely individual? Is it for adults, for kids, for couples? Can you tell us a little bit about that?

A. Sure. You have to be over the age of six. And I always joke; we service anybody over the age of six to 106. There isn't any age category or gender-based differentiation other than the fact that we don't see any children under the age of six.

The beautiful thing about Family Service is we recognize that people, human beings, are relationship beings. And so our

work is offered in individual, couple, and family. And what's fascinating is that the majority of our callers that are asking for appointments, at the first call intervention, they are speaking a lot about the relationship difficulties that they're having in life. And I don't mean ... Sometimes it's about intimate partner relationships; sometimes it's about greater familial relationships with parents; sometimes it's about relationships in terms of community context.

But we, as human beings, we have an immense need to be in relationships, and so we, our organization, it's important that we offer all three modalities of Counseling because if all we do is focus on the individual and we put all the weight of expectation on the individual, we're really not paying attention to the importance of the societal context and the fact that people experience mental health out here. They don't experience mental health within themselves only. And their experience in terms of on their journey to becoming well really needs to be contextualized to what's happening out in their environment.

Q. When a client approaches you or calls and says they may want Counseling, I take it you let them kind of tell you what they're looking for?

A. We do.

Q. And you're guided by what they're looking for?

A. We do. Often, clients and families don't have the language, right? And they're struggling to navigate this immensely complex system of mental health services. We have structured mental health, we have a complete influx of private practitioners, and we have us as a community-based organization.

So families and individuals have a very hard time navigating the system about where should they go and who should they see? And the mental health awareness campaigns have done a beautiful job of raising the awareness but, unfortunately, they have also created quite an awareness for people who are ... We seem to be creating an awareness that we all need professional help. And Stan Kutcher, in this province, has done a phenomenal job at trying to counter that.

There is a time and a place for professional Counseling and I lead a Counseling agency as an ED and I'm saying this and there is a whole lot of time when we need a lot less of the lower-tiered services and by "lower", I don't mean less important; we can talk about that in a minute but we ... and we need to manage our difficult emotions in a different way. But the mental health campaign has really pushed through and so there has never been a drive for the access to highly-

professional Counseling services as there has been in the last three or four years.

And so people are navigating that world and trying ... In their minds, most people feel like if they can access the top tier of the service ... and so in Mental Health, the top tier would be Tier 5 and that would be psychiatry and inpatient mental health. Mental health has a five-tiered system and Tier 1 in their language is population health.

So DCS also has a tiered system and they have a one to three system and they're really focusing on a lot of funding towards Tier 1. We are classified as a Tier 3 service within mental health and that means we just have licensing and we just ...

(10:00)

Q. Let me just ask you that, so I'm clear. You said mental health tends to ... The services that are provided in the area of mental health tend to be, I guess, ranked or classified in five tiers?

A. They are, yes.

Q. Okay, so five, top ...

A. Five is the most intense.

Q. So that would be seeing psychiatrists.

A. Exactly. And the top tier is the most expensive to community, right, and to our society.

Q. Right. And would your organization fit in one of those tiers in mental health?

A. We do, which is fascinating because when you sit where we sit and you get insight into all the government departments and you get insight into where there's commonalities, and where each government department has specialties. So, for example, the Department of Justice has a certain specialty and then they've got a level of, for example, supervised access and exchange where they've got a level of care that they're responsible for that is actually, might be similar or might be able to cross paths with community. You've got DCS, who provide child protection and income assistance and housing and all kinds of things, and then you've got this core work from them that crosses mental health, because they need to pay attention to family's well being because, if you pay attention to family's well being, then you're going to have less kids being taken into care. You've got mental health, who has got specialized service in terms of psychiatry and hospitalization, who nobody else can provide any of those things. We need them to provide those things. But as you move down into common tiers, like Tier

2 and Tier 3, you've got this commonality that kind of moves across Justice and Department of Community Services, which is that sweet spot where I see. That's where community steps in.

Q. So sort of in the middle of the tiers, would that ...

A. Yeah, or even ... I think of Tier 1. So Tier 1, and I don't know about Mental Health, I don't think they would consider this, bu I think DCS for Tier 1. I think of Tier 1 would be a service like a library. So a public library. I praise our public libraries constantly because of my longstanding work with men and people who identify with being men, and we'll talk about that. The libraries are a safe, nonjudgmental, warm place to spend your day. So if you're experiencing housing issues, loss of a job, and you've got all that stigma attached to being a male and not working, you need a place that you can be safe and walk in and still maintain a sense of pride that is not necessarily linked to a service. Our community libraries provide that. And we in Antigonish with our Men's Health Centre, we view that public library, especially because we're on the same block as an integral part of the service that we provide to men and people who identify as being males, but you would never think as a government department that a library is providing some aspect of mental health. You would

never think that and I'm telling you that they are.

Q. All right. No, fair enough. So your organization, I take it from what you re saying, would be somewhere in the middle of that.

A. Right.

Q. Less intensive than, say, seeing a psychiatrist.

A. Exactly.

Q. More than other community places where a person can achieve some mental health ...

A. Exactly. We don't get any formalized funding from mental health, from that structured mental health. We sit quite well within their tiers. Mental health, the system tends to keep its work around mental health quite to itself and there are beautiful opportunities for us to collaborate more fully. We get many, many, many direct referrals from Mental Health to our organization and so that's a piece of work that is very much on my radar to continue to figure out how can more closely work and collaborate with Mental Health so that there's a way that we can work with families that Mental Health cannot and ... yeah.

Q. So apart from just direct counselling, somebody calls and needs counselling. We talked about particular programs that you operate, so you do Families Plus. Are there other programs

that Family Services administer, run, operate?

A. There are many. The one thing I will, just to loop back to Families Plus, the one interesting thing about Families Plus is because the Department of Community Services in this Child and Family Division has paid a lot of attention to its own transformation and reflection. One of its guiding principles is reflection and anti-racist philosophy and paying a lot of attention to culture. And so Families Plus, we now have as the first time ever, we now have distinct funding for African Nova Scotian social workers who are delivering the intensive family based Families Plus program in and amongst the Central Region to, specifically to African Nova Scotian families.

So the reason I'm saying that is the Department of Community Services was recognizing that a level of care needed to be provided to African Nova Scotians that were coming into care and if those rates were higher or lower than the rest of the population. And so this very particular program was developed out of that. And the only reason I'm mentioning it is it's just speaking to the willingness to be flexible and responsive to what the needs of the community are coming out of and I so admire that. It takes a very brave government department to be reflective and responsive.

Q. It was seen that, I take it, that that may have been a gap.

A. Yes, exactly.

Q. Services provided to, for example, African Nova Scotians ...

A. Exactly.

Q. May have needed to be more culturally appropriate.

A. Exactly, yes, 100 percent, yeah.

Q. And has there been similar thinking, while we're on the topic, about assisting Indigenous clients?

A. Yes. Yes, that is where I think that that is ... That has always been part of the conversation and that will come, I think, in the next little while, for sure.

You asked about other programs. So something else in terms of another program that we've recently launched through the partnership with the Department of Community Services is called a clinical consultant network. So we have this beautiful network of family resource centres across the province and family resource centres are incredibly important in the mental well- being of families in and amongst the province and they are tucked into all kinds of communities. They do outreach and they are very inviting, nonjudgmental, and people ... families have a

way of showing up to them in a very beautiful way. The importance between partnering between government and not for profits is people show up to the not for profits in a very different way than they show up to the hospitals. When you're walking into a hospital to an appointment, there's a certain expectation that you have in terms of how ill you are, whereas you're showing up to a not for profit and, really, your perspective is how well you are. It's a very different mental capacity and so it's important that government and community work together because overall we're going to provide better care across the province. So back to the Family Place Resource Centres ...

Q. So the Family Resource Centres ...

A. Is a network across the whole province.

Q. I'm familiar, there's one in Antigonish.

A. Exactly, exactly.

Q. So your organization does what with ...

A. So they ...

Q. What's your involvement with Family Resources Centres?

A. Well, they kept experiencing families coming in and accessing their services that they, because of the mental health awareness campaigns, that they were beginning to see were

struggling with their mental health. And so they are a beautiful network of organizations and they are very aware of what their scope of practice is. And they were saying what could we do, how can we better enhance our staff's knowledge and support for working with these very highly complex families and helping keep our those families safe. And so DCS, in consultation with various other early intervention programs out of the States, out of Boston and Harvard University, they've implemented through us, were funded to provide, it's called a clinical consultant network. And so we have Masters level social workers and psychologists, actually on site at Family Resource Centres to provide support to those EDs and to those staff and to the particular parenting journey program workers to help them understand and unpack the complexities of the families that they're working with.

Q. A client family, for example, who accesses a Family Resource Centre, can they see a therapist there?

A. No, it's not that. It's to provide the support to the system. Not to the direct families, yeah. The care for the system is equally as important as the care for the individual families.

Q. A family who may be struggling and who accesses, say,

financially or emotionally, obviously often inter-related, if they access a Family Resource Centre, they can receive support and assistance, their emotional support, or be referred to your organizations.

A. For sure. Community is very ... Community, the not for profits are very aware of what their limitations are, what our limitations are. And we tend to be extremely aware of what resources are out there. And so if a family was to access a Family Resource Centre, I'm sure I'm not speaking out of turn, those workers would be very aware of what resources were available in that community because we kind of come from this philosophy is we can't do anything by ourselves and we're always better together. So they would most likely, if a family showed up in Antigonish, those workers would be very aware of Naomi Society, they would be aware of the Men's Health Centre, and of Family Service, and they would actually, what's even better is they know most of us by name and they would say, Listen, why don't you pick up the phone and phone Nancy, she'll whatever. So, yeah, they're aware of what the resources are.

(10:10)

Q. I know there are a number of programs but there are the big ones that you deal with?

A. Yeah, so we also are about to launch the Strengthening Father's Program, which is another funded through the Department of Community Services. Department of Community Services recognized that our men's intervention programs across the province, as much as they were reaching some of the intended population of men and people who identified as being male and who are at risk of being involved in family violence and domestic violence, that there was a whole lot of prevention and early intervention work that we were missing the mark on. And so they've, I guess collapsed is what I'd say. The men's intervention programs in a way, and they mobilizing this far more strength based holistic model called Strengthening Fathers and it pays attention to the three tiers and it pays attention to the need for a Tier 1 for access and engagement for men who people identify as being male, such as the libraries, such as drop-ins, such as organized get-togethers because man and people who identify as being male have an immense need to be in a relationship. They also recognize in that program that a Tier 2 would be like psycho-educational programming. So the need still is for emotional regulation programming, anger management, you know, respectful relationships, whatever the words are that you want to whatever call it. The psycho-educational programming

and then they also pay attention to that program to the need for the Tier 3. So there are going to be men and people who identify as being male who need formalized counselling and supports and therapy.

The beautiful thing about that Strengthening Father's program, and kind of DCS's overarching philosophy is that an individual doesn't stay in one tier. So an individual needs access to various tiers because the factors that occur to them on any given day determine what tier they need to access on any given day. And so the old way of thinking was that if you were a highly marginalized family and you were, let's say you needed therapeutic supports, that somehow that's all that you would need or that you would stay in that tier the whole time. These programs now that are rolling out are very aware that families' emotional states, they ebb and they flow and so there needs to be tiers that are appropriate to each of those levels.

Q. And implementing the Strengthening Father's Program that in this area at least is your organization going to be spearheading that?

A. It is. Tomorrow we have our first face to face across the province with all the Strengthening Father's service providers tomorrow for our first real six-hour look into that

program and what it needs to look like and some training around it. So it's exciting.

Q. Okay. There may be other ...

A. I was just going to say. Yeah, so something that we ... I could talk, I mean literally I could talk all day about the programs that we run but I'm sure that's not overly interesting to most.

The most important thing is early on based on my Guysborough days, and I had a supervisor, Cameron McDougall, long time Masters level social worker, and he identified a gap in Antigonish around family violence, domestic violence programming. And early on it used to be called Shifting Gears and he had created it himself based on various research and literature from a whole bunch of programs because nothing formalized existed.

Q. And that original program Shifting Gears, that was a program for men who had been found to have already, say, convicted of a domestic violence offence in court?

A. Yes, and it was part of their probation order to attend. The odd time someone would come forward who had identified feelings that were becoming unmanageable themselves and enter the program but, for the majority, it was almost all

probation-oriented guys.

And so, as a brand new worker, Cameron asked me to co-facilitate that. And so my very early on, since I've been with the organization, I was involved in that program. And it was really challenging work and, as a brand new worker, I was very aware of listening to the men's stories and, at the same time, understanding the importance of this emotional regulation work and what kind of the overall tenets of Shifting Gears was, was paying attention to what was happening in these guys' lives and trying to hear that they wanted to and react differently.

When Cameron retired and Department of Justice kind of rolled out their Respectful Relationships and their tiered programming for domestic violence, and we've been involved in that right from the very beginning. We've been involved in the domestic violence courts in Sydney from the very early on. We were one of the service providers in Sydney for the higher tiered domestic violence work, which is like a 27-week program. But Respectful Relationships was a program that was, it's psycho-educational and it was pretty structured and so we collapsed Shifting Gears and we said we're going to take on this more evidence-based program.

Q. When did Respectful Relationships, when was that

rolled out?

A. So it was after Cameron retired and then I became a director and I had a say in what types of programs we were going to start to run. It was probably back in, oh, geez ... Well, Cameron was still there because one of our kids was born in 2000. I'm thinking like 2003, somewhere in that kind of general area is when we first rolled out Respectful Relationships.

Q. And, again, Respectful Relationships was for men who had found to have already abused.

A. Yes. And the majority of referrals came from Department of Justice and we worked really closely for a long, long time with Community Probations. Community Probations, if anyone ever wants to know people who are intimately involved in the well-being of individuals and communities, it's those community probation officers. They do a phenomenal job at supporting and hearing and advocating for the individuals that they have on their caseloads. I always have to give them a shout out no matter what presentation, I know this isn't a presentation. When I'm talking about the trauma work, I always say, again, let's not lose sight of the fact that those community probation officers. So the community probation officers would make the referrals. The Department of Community

Services would make the referrals to Respectful Relationships but the problem with that was it was a closed group, it was a 10-week program, and for Department of Community Services, their court timeframes, often they needed access to the group in a more timely fashion. So for 20-some odd years, we ran either Shifting Gears or Respectful Relationships twice a year, in the fall and in the spring.

And so when I became the primary lead in Respectful Relationships, then I was tasked with actually sitting and doing the assessment with the guys. And prior to that when I was new with Cameron, he did all the assessments. So I had kind of missed a real important section. I'm getting to the point here. When I became the primary lead and I began to listen to the stories of these guys, and they would have to sit with me prior to coming into the group and there was this form that I was supposed to be filling out in order to get into the group and I kept being very upset at these stories that I was hearing. By upset, I mean it kept shaking me because they were talking about really foundational needs in their lives. They were talking about housing. They were talking about chronic pain. They were talking about relationship stuff. They were talking about loss of jobs. They were talking about grief over loss of family

members. And I kept thinking, trying to struggle as a therapist with, Okay, how do I hold your story and all the details of your need and at the exact same time I'm supposed to be leading you through a domestic violence assessment and eventually putting you into a group that's going to teach you how to emotionally regulate. And I was really struggling with how do I put those two things together. How do I ... Do I just ignore all these needs and not listen and just move you in? And that seemed like I was going to actually create some sort of ethical trespass, right. But I couldn't actually do that.

So I started to think, okay, well, let's just have a whole bunch of other resources available to these guys. This is me in my naive 20s. Why don't I just reach out to a whole bunch of different people and get some of these needs met. And so I began to look out into the communities I was providing service to, in Guysborough and Canso and Antigonish and New Glasgow, and there wasn't anything. There wasn't any services that were specific to men and particularly around the needs that they were expressing. And at the same time, and there's a relevance to why I'm talking about this, too.

At the exact same time I was in ... My husband and I were having our kids and my husband was staying at home and he was

experiencing this situation in the community where he would go out with our kids and he wasn't working and a lot of the programming was strongly languaged towards mums. And so he would say to me, I just can't go there. I can't go to Mums and Tots and take the kids swimming. I can't go to ... And I remember thinking, huh, that's interesting. You're a good dad. I'm not sure about that. It was just trying to percolate up. And then I had, we had some sons and some daughters and I began to think, wow, what if my sons, fast forward, and what if they need something in their lives. What if they need care or support, and I'm pretty sure they're going to, who is going to provide that? And all these things came together, again with these hundreds of hours of stories of my guys that had come through Respectful Relationships, and I said, Okay, we need to do something here. This is a gap. This is an emerging gap and, if we can step into this gap, what potential changes can we make in the world.

(10:20)

And so I began to just have conversations with other like-minded people, around what would it look like if we had a Men's Health Centre. I know we have a Women's Health Centre and I'm thrilled and proud of the fact that we have a Women's Health

Centre in Antigonish but what would it look like if we had a Men's Health Centre. And we had a lot of people say, well, no one will come because men don't access care. And I remember thinking, okay, maybe. I'm not sure because that's not what all these guys are saying. These guys are all saying, if there was something, that we would attend. And so we did a lot of brave steps and we took a lot of brave ... had a lot of brave conversations. And when I say brave, it's because when you're trying to do something new, and all you really have is your gut instinct based on what ... And you're carrying the stories of your clients with you, it's not often the most popular stance to take.

And one of the things that I heard, after all those hundreds of hours of stories was access to health care. And I don't necessarily only mean mental Health, there was that. But the guys were saying that they had access to physicians. Like there were, most of them were orphan patients who had not had access to a doctor in years. And I'll tell a story, this was this one guy and I was supposed to be doing my Respectful Relationships assessment, and I will tell you, I did actually complete all the assessment, just if anyone is ever wondering if I did. I did actually do them all. And he's sitting there and

he's struggling talking to me and I can't quite figure out what it is. And the old way of doing it would have just been, I would have just kept asking the questions, right. Get through the form so I can move on to the next person. But a part of me was like I can't move forward until I ask you what's happening because it feels extremely disingenuine and disrespectful. And so I said to him, Can I just stop you for a second? Can I ask you what's happening right now with your mouth? And he says ... he sits back and he lets out this big breath of air and he says, I'm experiencing immense pain and I have absolute massive tooth decay. He said, I was in a fight on the street a long time ago and I have disconnected teeth from my roots and he said I have actual chronic pain all day long. And actually when I zoomed in and looked, and I thought, I've never seen black teeth, like black black.

And again, then I asked another brave question and I said, What impact is that having on your life? And he said, It's impacting everything. He said, I lost my marriage. He said, I'm in a new relationship, which is why he was referred for Respectful Relationships. He said, I'm angry all the time. I can't be intimate with my partner because my breath is so bad. I can't eat because I can't chew. And he said, I'm hungry all

the time. And I remember sitting there thinking, Holy jumpin', I cannot just teach you how to emotionally regulate. I have to do something different. If I don't do something at this end of it, then no matter how many hours you spent in this course, it's not going to make any difference because I haven't paid attention to your underlying foundational social determinants of health, the stuff that's going to give you a foundation to live on. So I said, Okay, let's continue with the assessment. Do you give me permission to start to have conversations with people about what we can do about this? He's like, Yeah, absolutely. You think you can actually help? I mean I don't know if I can. I don't know if I can help. I don't know what I can do but I just feel like, ethically, I really need to do something.

So I just started having conversations and dental, of course, there isn't dental health in our systematic health care around dental care. And so I found a like-minded dentist in Antigonish and he was wiling to do a bit of work for me. I found a volunteer to help me get this guy to his appointments in Halifax. Anyways, fast forward, this isn't about me, this is about a willingness to step into a gap as you saw it and pay attention to more of a holistic view of health care.

Fast forward two years ago. The guy has a full new set of dentures and he popped in. And he said, I just need to tell you that I'm feeling great. And I said, Okay, that's fantastic and how are you, you know, how's the anger. He said, The anger is gone. He said, I can manage my anger. He said, Without the chronic pain, and with my ability now to feel healthier and to be able to lean into my relationship, he said, I can parent, I can be present to my kids, I can be present to my partner. And the story has stayed with me forever because it was so important for me to never lose sight of I need to pay attention to helping keep people safe. But I need to do it in context of their lives. And the two are two intimately connected. If I only play my expert role of doing what I'm supposed to be doing in my job and I lose sight of what a person is actually saying to me, then I'm not keeping anybody safe.

Q. It's a very compelling story. From those experiences, the Men's Health Centre grew?

A. It has grown.

Q. So tell us about that. What is the Men's Health Centre that you operate out of Family Services?

A. The Men's Health Centre is, it's a beautiful service and it came out of a place where there ... it is still the one

and only in the province but it came at a time when people were really ... We saw a need in Family Service for people to begin to talking about the needs for support for men. And this is never without the context of knowing that we also have to keep people safe and that women and children still are at a higher risk of harm in this province and in Canada than men.

But it's also paying attention to, what would it look like if we put resources into kind of a prevention, early intervention side of things. What if we made those more robust so that we could ... men could feel part of this fabric of society. And so we opened the Men's Health Centre in 2008 or 9, somewhere in there, and it's a one day a week service and we did it intentionally without any funding.

You asked about our funding services. I'm very aware of funding. I'm very aware of grants. I'm very aware of core funding. But the Men's Health Centre, the work seemed so critically important that funding also comes with the risk of funding being removed and so instead we moved ahead with memorandums of understanding.

So on a Tuesday, anybody 12 years or up, any guy, anybody who identifies as being a guy can walk in or make a phone and you can get an appointment with a family doctor, a mental health

worker, a family therapist, and we've added a navigator.

When we first started to present that, people would say, Men aren't going to come, they don't access care, and again I have a different experience. As workers, it's important for us to pay attention to kind of a combination of our self life and our theory. We aren't very good workers if all we do is pay attention to our theory. We have to show up authentically. So we have our life story which is why, as a mum of boys and watching my husband navigate the world as a stay-at-home dad, and then I have my sense of self and so, you know, allowing yourself to be kind and caring and compassionate in this world is important. So you carry all those three things forward and we launched it and we opened it and the phone started ringing. And the phone in the beginning was from mums and grandmas and sisters and wives, Can I make an appointment, can I make an appointment? And we would say, No, you can't make the appointment. We need the person in your life that you're caring about to call. That was a foundational point that we never wavered from. We said two things. One, we need the guys to call themselves or the people who identify as being male to call themselves. And you cannot mandate this service. And the reason we protected those two things is from the family service

side of things, I saw the importance of mandated service. And when I say mandated, I mean Department of Justice required.

Q. Somebody on probation.

A. Somebody on probation. Or Department of Community Services, you're involved in that highly specialized child protection and you are strongly encouraged to attend something. We need those programs but we also need space where people can authentically show up in a time when they feel that they need it. And so we said to the Men's Health Centre, you can't tell anybody that they need to come here, because we're not taking mandated referrals. If you want that, then we'll put you to the Family Service side of things. And you have to call yourself, if you're a guy or anybody who identifies as being a guy. And it has not stopped.

So we have, guys travel from seven counties. We have programming that occurs weekly on that one Tuesday. The most beautiful piece of that work is the advocacy that it has created. It has started to create space and change in the conversations that people are having around what does support look like for men and people who identify as being male. And what are their needs. And what are their health-seeking behaviours. And what else is necessary. And so it started at a

time when it was very nerve wracking to actually say that we were going to offer something to men, it's now transformed itself this many years later into being a very important part of every conversation, is how are we going to provide service to men differently.

Q. When you began, did you experience resistance to the idea of ...

A. Yes.

Q. ... providing those types of services to men who may be offenders or who might become, might have issues with anger, for example, who might need some of those underlying problems in their life or challenges addressed?

(10:30)

A. I know. Yeah, a lot of resistance. And I spent a lot of time reflecting on that resistance and I can see that resistance now coming from a good place, coming from a place of really wanting to keep women and children at the forefront of safety and I can see where that resistance came from but we had phenomenal resistance. And I, yeah, and we continue to move forward because I continue to have those stories, those hundreds of hours of stories of those men in my head. That's what I led with and it's not an either/or. It's not that you want to get

rid of highly specialized services and psycho-educational programming that are meant for people that have already moved into risk behaviour or what we would consider to be, you know, you're already engaged in family violence or domestic violence. It's not that, we need those.

I mean, I did that for the probably the longest running domestic violence program in the province's history; I was the facilitator of that, but what we do need is something else. We need space for men to show up themselves, safety and control over that process. We need places where we're attending to the significance of their actions.

So when a guy would sit in front of me ... I remember another gentleman came at the Men's Health Centre and he said my family is really worried about me and I said, So, you know, why? Why is your family worried about you? He said, Well, I'm not myself. And I said, Okay, well, what does not yourself look like? And he said, I'm crying all the time, and I said, Okay. He said, They think I need hospitalization.

And I remember thinking, see, this is where people go, right. As soon as something happens, particularly with men, that we skip the tears in terms of do we need specialized services. I said, Well, can we talk a little about those tears

and are they new, are they ... where are they coming from, do you have any insight into that?

Part of the trauma language that we're trying to embrace is an awareness that people have embodied knowledge about what they need and what's happening to their body. Trauma applied from a health perspective is from the specialist down, so the expert decides and identifies trauma as a diagnosis almost and says this is something that I will label as trauma. Community version of trauma and violence informed comes from the process of becoming overwhelmed.

And so it's not my job to identify and to diagnose, I don't have that qualification, but this gentleman is sitting and he's saying, Well, I'm thinking that this particular significant event in my life has impacted this. And I said, Well, so what is this significant event if you don't mind sharing it with me? And he said, Yes, I became, you know, the primary caregiver of a family member, of a young family member, and he said, you know, I've ... I, you know, wasn't a great father to my own kids and this particular individual family member I became completely invested in, I became a really good dad, and this individual has just passed away. And in my mind, as a professional, I'm thinking loss, tears, those two things seem like a pretty good

combination, right.

I said, What is it that you need to allow yourself permission to actually grieve the loss of this important family member? He said, Well ... he said, I can't do this. He said, I just ... you just need to tell me how I'm going to get rid of these tears, he said, like this is ... these are not okay. I'm crying. I'm a long truck driver, you know, I can't do this. And I said, Well, what if it's your body's way of responding to this profound loss? He sits back and he's like, So these are okay, these tears? I said, Yeah, they're okay, they're okay.

And I remember thinking, Holy jumpin', how are we going to get to this place where this is ... these are okay conversations. And we don't necessarily need a structured hospital to have those conversations. How do we lend its support to these community places where these conversations and this space can actually be had? Go ahead. Go ahead.

Q. So obviously one space is ...

A. One space. The Men's Health Centre.

Q. ... the Men's Health Centre.

A. Yes. And so ...

Q. Are you seeing need for more spaces like that?

A. Yeah. Yeah, more spaces. More spaces. We, again,

have a hard time keeping up with the requests. We also have a hard time putting it in places. We've never moved beyond bricks and mortar in Antigonish. So the Family Service organization shuts down on Tuesday and we just lend our space to this Men's Health Centre.

The family physician that offers her time on Tuesdays is extremely busy. The Emergency Department makes direct referrals, passes out ... they have our cards at the Emergency Department. The need ... as we are fully aware in this province a shortage of family doctors who becomes most vulnerable are the orphan patients. And when we talk about ... might as well go there now, the social determinants of health. So the Public Health Agency of Canada years and years and years ago through immense research and literature created these 12 social determinants of health and they are quite Canadian and they're quite internationally known, the World Health Organization lends credence to them. And so often we forget all this good stuff and we try to create new stuff.

But if we live to the social determinants of health these 12 factors are foundational factors that are important to Canadians to pay attention to that are going to lead to their overall well-being. And the reason I'm talking about the social

determinants of health is because when we're talking about mental health we sometimes make it too insular and we don't ... we lose complete sight of the context of the social determinants of health and the impact that they are having on a person's mental health.

And so the Men's Health Centre tries to be grounded in the social determinants of health. So we try to make space for the fact that a loss of employment, the loss of a job, a loss of an income, a loss of a relationship, a new person to a town, culture, race, all of those social determinants of health are crucial to men or people who identify as being male.

And so all that we had prior to the Men's Health Centre was a mandated service of respectful relationships and you had to wait until you actually went through the courts and were charged before you actually got into the program. The Men's Health Centre provides a totally different philosophy. The Men's Health Centre provides a space for the guys to show up before they get to that highly-tiered service.

Q. Right. So a man who might be feeling overwhelmed ...

A. Yeah.

Q. ... or stressed because ...

A. Mm-hmm.

Q. ... as you say one of the social determinants of health in his life may be challenged ...

A. Yeah.

Q. ... at a given point of time, or maybe it's economic, maybe it's ...

A. Yeah.

Q. ... well, what have you. Before he gets to a point of committing an act of domestic violence if he comes to you maybe that can be addressed. Is that the idea?

A. That is the idea. The idea is prevention, early intervention, robust symptoms at that level for men and people who identify as being males will help mitigate the need for the highly intensive services.

Q. And let me just ask you, you had said I think earlier your particular Men's Health Centre has a doctor that comes ...

A. Yeah.

Q. ... a family doctor who comes one day a week?

A. Yeah.

Q. And you have other professionals there as well?

A. Yeah.

Q. What were they or who were they?

A. We have a mental health worker through Mental Health

and Addictions, and we have myself who does the family therapy. And the reason I've asked permission from my Board when I became executive director to hold a one day a week frontline position still because it keeps me, I feel, ethically tied to the actual work, and I feel like I make better decisions as an ED around funding and around program decisions when I'm actually still engaged in hearing the stories from the clients that are going to be most impacted by my decisions as an ED.

Q. Right. So Mental Health and Addictions, family doctor, yourself as a family counsellors ...

A. Yeah.

Q. ... and therapist. Who else is there?

A. Yeah. So over the years we've also had a navigator position.

Q. So what does a navigator do?

A. Yeah. So that actually came through ... you had the Status of Women, I think, provide testimony yesterday, so through a SHIFT grant through the Status of Women, the Standing Together initiative, we had a navigator a the Men's Health Centre. And the navigator was helping kind of zero in on those other social determinants of health, so housing, job security, the things that were harder to get to.

Navigation amongst systems is extremely complicated and what happens when an individual is becoming increasingly under duress, as we know from the trauma literature, trauma is really the process of becoming overwhelmed. And the more social determinants of health that you are ... the more factors you have at risk then the more along that trauma journey you're journeying. And as you continue on in your duress the less ability you have to make critical decisions and so your brain works differently. Like the research shows all that.

And so what happens is we were hoping at the Men's Health Centre, if you found yourself there and you were under duress knowing that it's difficult navigation becomes difficult because your brain is not working in the same way. It's hard to keep track of the appointments. It's hard to keep track of who, what position are you attached to, are you government, are you not government, who am I supposed to talk to.

When I listen to some of the guys' stories about how many people they have in their lives I am amazed that they are keeping it straight, actually amazed. And so the navigator position was really just another gap that we thought we could help fulfill in terms of job security and housing and linkages between income assistance and all those other places.

Q. So a guy comes in and he's feeling overwhelmed, he's looking for housing and he's trying to deal with one government department, he's dealing with other government departments, the navigator will assist with that kind of work?

(10:40)

A. Yes. Yes. And the beautiful thing about the Men's Health Centre because we're all in one space typically we've found that the guys and people who identify as being male have language around doctors. So there's a comfort level with asking for an appointment for a doctor. There's less language around accessing a mental health worker or a family therapy or a navigator.

So what typically happens, although we're starting to see this transformed, the majority of guys wanted to come in and see the family doctor. But the beautiful thing because we're all literally all nextdoor to each other in the same building, she'll meet with them, she'll have a chat and then she'll say, You know what, I think I have ... I think you might be better off served by my co-worker, Nancy, or my co-worker, Mike, he's our addictions counsellors. Would you feel comfortable with me making an appointment or seeing if he's available right now? So like there's this little triage thing happening amongst us.

One of the things that our systems don't do well at and it's a bit ethically ... again, it's ethically not a great place to be, is we tend to refer clients. Like we lobby balls back and forth, right. So we just make a referral, it comes across a fax machine, it's a person's name. The Men's Health Centre was trying to pay attention to the relationship-based needs of men and people who identify as being male and so if we paid attention to our relationships as co-workers and our knowledge about what each of our scopes of practice was then we would be able to provide better care to the guys.

Q. And you still have the navigator position or ...

A. Yeah. Well, there's not somebody in it currently right now and that grant is done but, yes, we still play that role but there's not a body in that.

Q. Because the grant is done?

A. Right. Yes. Yes.

Q. You don't have funding for it?

A. Right.

Q. You would like to have funding I assume for that so you could have a navigator again?

A. Yes. Grant funding is extremely complicated. As an ED, grant funding is a joyful thing and a painful thing at the

exact same time.

Q. Yes.

A. So, yes, the need is there.

Q. The need is there.

A. The need is there.

Q. Yeah.

THE COURT: Did you have a navigator ... you had a navigator previously though? Did the funding for the position ...

A. Not early on we didn't. Just recently with that Standing Together and our Men and Boys program, we had funding for that position.

THE COURT: Okay. And what, so what happened to that funding, did it just run out?

A. Yeah, the grant is done. The Standing Together Initiative, the SHIFT grant is finished.

THE COURT: Yes.

A. I'm not answering your question.

THE COURT: Well ...

A. No.

THE COURT: ... maybe it's how I'm asking the question.

A. That's okay.

THE COURT: So there was programming and there was funding in that programming for a navigator?

A. Yes.

THE COURT: And that program funding came to an end.

A. Yes.

THE COURT: The program came to an end.

A. Yes.

THE COURT: The navigator's position, funded position, came to an end.

A. Yes.

THE COURT: Now you are looking for funding, perhaps more permanent funding, long-term funding ...

A. Yes.

THE COURT: ... so that you can have a navigator in place ...

A. Correct.

THE COURT: ... for into the foreseeable future?

A. Correct.

THE COURT: Go ahead to keep things organized.

A. Much more articulate than I am, yes. Very much so ...

THE COURT: Well the thing is that I'm still ...

A. You got it.

THE COURT: ... I sit here ....

A. You got it.

THE COURT: ... and I kind of pick through all of the language that you use ...

A. Yes, I know.

THE COURT: ... it's not language that I would normally ...

A. Yes.

THE COURT: ... use, just to get in straight in my mind, because I am going to ask a question about navigators and case managers in the Veterans Affairs' context in a minute. But I'm not going to interrupt Mr. Murray yet.

MR. MURRAY: Oh, that's fine.

THE COURT: No, go ahead.

MR. MURRAY: Shall I keep going? All right.

So you had funding from the Standing Together grant and that has ended?

A. Mmm.

Q. And that's, I guess, the nature of your business. Grants start, they end; money comes, money goes?

A. Yeah. Less now. As an organization and as an ED I'm very careful with the grants that we apply for, they are few and

far between. There are a lot of grants available but it is impossible to sustain programming through grant funding. And so I am now far more creative with figuring out ways to core fund within our operating budget and our social enterprising contracts and everything else. If we see a need which is why ... where I was going. If we see a need ... for example, never turning anybody away from Counseling, we have become very creative in finding other ways.

The grants are ... I understand the vehicle and I understand the need for them, but the beautiful thing about that particular Standing Together grant it was a substantial grant, it was a SHIFT grant, so it was bigger than one of the community grants. And so it allowed for quite fundamental system change within our Men's Health Centre and the awareness and advocacy work for men and boys within our local area so ... But grants are problematic.

Q. I heard that phrase yesterday "it's a SHIFT grant." What does that mean?

A. I think it's an acronym but I'm not sure what it means.

Q. Yeah, that's what I assumed. Okay.

A. Yeah. So I'm hoping you're not going to ask me. But

it just meant it was more of a substantial grant and it was really dedicated more for system transformation.

Q. Okay. All right.

THE COURT: So the money that comes from the Standing Together program ...

A. Yes.

THE COURT: ... has that run out totally for you ...

A. No ...

THE COURT: ... for the ...

A. ... interestingly enough. That grant has, the SHIFT grant has.

THE COURT: Yes.

A. So if we want to fast forward to there. So we're in the throes of the beginning of the pandemic and we are all doing as much as we possibly can to uphold the work, particularly around the Men's Health Centre. So understanding that the Men's Health Centre is a one-day a week program that is run by Family Service of Eastern Nova Scotia amongst many, many, many other programs. So we're trying to pay attention to how we get mobilized the doctor's care and the mental health, and how are we going to protect that program.

And at the same time the men's intervention programs across

the province are beginning to see an increased need for mental well-being supports from the men that they support in their programs. And at the exact same time, but we are all ... we're not aware of this until finally DCS and the Status of Women pull us altogether, 2-1-1 has identified a 75 percent increase in male or people who identify as being male callers early in the pandemic looking for support so ...

MR. MURRAY: So just ... I know we're going to talk about that ...

A. Yes.

Q. ... but let me just ask you now. You said 2-1-1 has identified that?

A. 2-1-1. Yes.

Q. So what is 2-1-1?

A. So 2-1-1 is the Province's navigation system. So the 2-1-1 is now a nationally ... it's national across Canada, I guess that's what that means. And locally what it does is you can call a single number 2-1-1 and they have access to whatever resources are available in the province. It's fed by community and by government, so the database is as robust as we all put into it.

So, for example, if you were looking for family Counseling

in Antigonish and you called 2-1-1 and you said this is what I'm wondering about, 2-1-1 we have created a data chart in that system that says you can access family Counseling in Antigonish and this is the phone number that you phone.

So the Province had recognized years ago that we're a pretty tiny province so that, you know, we should be able to do this. We should be able to navigate systems and that people need a single entry point in order to get access to that. And so it's not just mental health supports, it's food banks, it's family resource centres, I mean, it's justice programs, there's all kinds of information within the 2-1-1 system. But 2-1-1, as an organization, was seeing a spike in predominantly male callers in the beginning of the pandemic.

Q. Pandemic, okay.

A. So Department of Community Services and the Status of Women, Heather Ternoway, she's involved in this as Women Standing Together grants, they started to have conversations about how we were going to mitigate through the pandemic; how we were going to make sure that we were paying attention to domestic violence and the potential for an increase in domestic violence and family violence during the pandemic.

If you've got spikes in males and people who identify as

being males calling for support and you've got the men's intervention programs feeling the same and you've got services kind of mobilized from people's homes is that potentially increasing risk for the citizens of Nova Scotia.

And so I got a phone call one day and they said, Would you be able to ... we know you have the Men's Health Centre so you've got this philosophy of providing care and support for men at the same time as balancing the higher-tiered specialized service of intervention around the domestic violence and we know that you already do 24-hour help lines, and by that they referenced the Families Plus Program. For the first time ever, families that are involved in that program actually have 24-hour support by telephone to a social worker. So if you were ...

Q. That's part of the Families Plus Program?

A. Yeah. First time ever funding came with a 24-hour model. That, you can imagine when that got asked and we needed to transform our entire agency. Our agency was an 8:30 to 4:30 agency and the ask came and I'm sure my Board and my leadership team at times say, Would you just say no Nancy sometimes. But I said, Yes, yes, we can do that.

The beautiful part about transforming it is we became wide open to understanding of course parenting issues don't occur

only between 8:30 and 4:30. Parenting issues occur at bedtime. Parenting issues occur in the morning. Parenting issues occur when your teen doesn't come home at 2 a.m. So why wouldn't we have parenting support 24/7. It was a beautiful wake-up call for us. And from that moment we've transformed our hours, completely flipped them on their heads. We're open five evenings a week now and 24/7 for lots of the programs, which is great.

So fast forward. I get the phone call from DCS Early Intervention and Status of Women and they say, We have an idea. We're wondering if you could help us launch a 24/7 men's help line and of course I am a hundred percent yes.

Q. So this ask came from DCS ...

A. Yes.

Q. And Status of Women?

A. Yes. Yes.

Q. The idea of a men's help line?

A. Yes. Yes.

Q. Okay.

(10:50)

A. So a couple of things are happening at this point. One, we as the workers and the decision-makers of the Men's

Health Centre were already seeing for a very long period of time the immense limitations of our 8:30 to 4:30 structure. I mean it didn't ... it wasn't going to take a rocket scientist to know that men and people who identify as being male aren't only going to have concerns on a Tuesday, right, but we couldn't figure out a way not through funding, not through memorandums of understanding, we've never been able to figure out a way to make that more robust, and then certainly not ... I mean, we'd always envisioned that service would be able to be 24/7. But the beautiful part about transformation is when things all come together at the same time. So we were a yes. They had the idea.

All the local community stakeholders, like the Men's Intervention Programs, they were all very much aware that this was something that was needed to happen, all the stakeholders engaged with conversations, it mobilized itself in a very quick period of time. I think it was a matter of a few months and we were able to mobilize it. We are just over a year into launching the Men's Help Line and ...

Q. So the Men's Help Line launched in when?

A. In September of 2020.

Q. Okay. And that came from? The genesis of that was

this call from DCS ...

A. A hundred percent.

Q. And the Status of Women?

A. A hundred percent.

Q. And there's money attached to that I think is how we got started on this.

A. Yes.

Q. There was another grant for that?

A. Yes. Yes.

Q. Okay.

A. Yes.

Q. And so the Men's Help Line that you created it's your counsellors and therapists that are involved in that?

A. Yes.

Q. Okay.

A. All us right now, but the goal is ... so we said, one, we have this knowledge and we have this philosophy about working with men and people who identify as being male, so yes, we can do this.

The goal, as we move forward ... so the Men's Help Line is two aspects to it. It's a single call, so you can call as many times as you want in a 30-minute session with a social worker or

a therapist but then you also have the option of ongoing Counseling. The goal with the ongoing Counseling is to mobilize the work and the philosophy of men's intervention programs across the province and eventually, if a male caller needs ongoing Counseling that they would be able to secure that in their own community.

The goal is for us to not be the only sole providers of this service. We are all about not needing to own anything. Just about how are we going to get people involved. So I have these dreams of how are we going to link in the ... how are we going to, you know, navigate the network of private practitioners or how are we going to mobilize people that are working in communities like, let's say, Cheticamp. Is there a possibility of having the face-to-face Counseling, ongoing Counseling for this guy if it comes through the Men's Help Line actually in his own community in Amherst or in Truro and we're not there yet. So right now it's still all us but it's not going to be all us eventually.

Q. So let's back the train up a little bit.

A. Yeah.

Q. So ... okay, so the idea was for something that would be 24/7 for men in crisis ...

A. That was the main ...

Q. Can I say that?

A. Yes.

Q. Okay. Or men who need help or men ...

A. Yes, all of the above.

Q. ... who want access ...

A. All of the above.

Q. ... yeah, to services. And so how was it structured? What was ... how were men to access this men's help line?

A. Well, I said ... we said right from the beginning based on all my listening ... and it's important to listen as much as we talk. Even though I'm talking a lot today I have listened a lot too. And the guys kept saying they need something that when they're starting to become ... when they're starting to feel emotions that are too big for them and they begin to lose the ability to critically think, they need something simple.

So don't put out a whole bunch of 1-800 numbers and you call this in this time, you put one ... you make it very, very, very simple and concrete and you stand behind what you say. So if you say that this is accessible 24/7 then you have to make sure that there is a body, a live body, a warm, caring body at

the end of that phone every single time.

Part of what happens in systems is systems promise things and then systems don't deliver and it creates great duress for people. So we said we've learned too much from the care that we need to provide for men and boys from the Men's Health Centre and we need to implement those philosophies in a help line.

So we said it needs to be staffed by warm, caring people, it needs to be a single entry point and it needs not wait list-oriented or it needs to be timely. So if you're feeling ... if you're 10 o'clock at night and you have had an unpleasant argument, and I don't mean an argument that's been violent, I mean an unpleasant argument with your intimate spouse or your girlfriend or whatever you want to classify that as and your feelings are becoming unmanageable, you need in your mind something simple: this is who I can call and I can be promised that they're going to hear me and work through me so that my feelings and my emotions can become more manageable.

So 2-1-1, we had never partnered with 2-1-1 prior to 2020, and DCS, because they're very aware of all the community ... 2-1-1 is also a community not-for-profit, a very large one, but they're also not-for-profit. And when we came together the commonality in how we provide care and the passion for providing

care for citizens of Nova Scotia was just immediate. And so they are a beautiful organization. Their navigators are very skilled and trained. You can imagine, there's nothing between them and whoever happens to call from all of Nova Scotia into their phone number and so they are phenomenal navigators.

So their navigator, a guy calls no matter what time of night and he can either directly ask for the Men's Help Line or through the conversation with the navigator the navigator has enough skills and is knowledgeable enough about what the services of the help line can offer them they can recommend the help line.

Many times when people are in duress, they don't have the language to say ... they're not articulate. They're not I need to talk to a social worker at Family Service. We expect that articulation but we misread that articulation. And so part of what the working together collaboratively is the more we are aware of all the resources together, community, then we can help people, inform people.

Instead of putting the expectation of all the knowledge on the individual we can put the expectation of knowledge of the resources on to us as workers. So we tried to make it simple. You call 2-1-1, there's no wait list, there's no ... it's an

immediate. It's called a warm transfer. As soon as that request ...

Q. We've heard that term before.

A. Yeah? Have you? Okay, yeah. I love that word, it's such a beautiful way of care compared to the faxed referrals with the names on them. It's such a more humanistic view of passing information on.

Q. So the idea of partnering with 2-1-1 is that it's simple?

A. So simple.

Q. Right. Okay.

A. So simple.

Q. And it's accessible 24/7?

A. A hundred percent, yeah.

Q. Obviously there has to be a bit of an education piece so that people know that 2-1-1 ...

A. Yes.

Q. Because I have to admit I wasn't fully informed about what 2-1-1 could do ...

A. I know.

Q. Or what was on the other end of that. So that's, I assume, something that needs to happen but ...

A. Mm-hmm.

Q. It's the guy that you said, the 10 o'clock at night guy who's had a fight ...

A. Yeah.

Q. Who's feeling overwhelmed ...

A. Yeah.

Q. And is having difficulty thinking clearly and may need to talk to somebody, if he calls 2-1-1, whether he knows that your Men's Help Line exists or not, if he does he may ask for it, if he doesn't the navigator at 2-1-1 may put him on to it?

A. That's right.

Q. Okay.

A. They'll kind of ... they have their own internal. And I wouldn't want to speak to knowing everything about their shop, I just think that they're a beautiful shop that's really quite willing to be reflective and flexible. But their navigators would kind of at that moment make a decision.

And so in terms of males or people who identify as being males accessing 24 care you kind of have a choice of mental health crisis or now the Men's Help Line. And so those navigators they have training and skills where they would place a call.

We actually have monthly calls now with the manager, Matt White, he's a great guy from Mental Health Crisis, in trying to figure out the synergy and the overlap between the Men's Help Line and the Mental Health Crisis. So that we view there is this place where Mental Health Crisis we need it. They are a highly specialized service and we need it to be for the people who have moved into becoming very unwell. But there's this place of connection between the service that the Men's Help Line provides and Mental Health Crisis and that we want to work more robustly together with Matt and his team so that we're not lobbying clients back and forth, right.

People can be in duress and then balance themselves and in duress and balance themselves, so there is this overlap between the two lines but the onus is on us to work with crisis to figure out those overlaps, but ...

Q. Right. So if the man who calls 2-1-1 comes to you ...

A. Yeah.

Q. ... is either directed or asked for ...

A. Yeah.

Q. ... your Men's Help Line ...

A. Yeah.

Q. ... that's also 24/7?

A. Yeah.

Q. Okay. And what can ...

A. What happens?

Q. What happens? What can you provide for the man who calls ...

A. Right.

Q. ... and needs help?

A. So it's barrier free, and by that there was a lot of stories over a lot of years at the Men's Health Centre about barriers to access. So the bricks and mortar, so not being able to physically get themselves to the Men's Health Centre, about limitations to the timeframe of services. So they're closed at 4:30 and I'm in duress over supper because we've had a massive argument and it's 7 o'clock and I don't have anyone to reach out to, and language. So the Men's Help Line and 2-1-1, we both have contracts with the Help (sic) Line so that both of them are accessible in multiple languages, like 72 to be honest with you ...

Q. Okay.

(11:00)

A. ... so yeah. Which was another big transformation for our organization, we typically are almost exclusively English-

speaking services. And so we've begun to pay a lot more attention to the changing transformation of the citizens of our province and how are we going to make sure that if we say services are accessible then they are accessible in a language that is most fitting to a person.

As a person moves through levels of duress, you can imagine if it's a second language that becomes even harder to articulate the words about emotions and feelings, right, so we have contracts with the Language Line but you'll get a warm transfer. There's never a break in the call, which is what we wanted it to feel like. It's what it feels like at the Men's Health Centre. If the family doctor says, You know what, I really think you would enjoy a conversation with my colleague, Nancy, and this is who she is and she's right here. And I'll shake his hand and, you know, it's like a warm transfer.

So 2-1-1 will stay on the line and our social worker will answer. And they'll say, Hello, Miranda, I have Bob on the line and I think Bob would like to chat with you for a bit. And our worker Miranda will say, Okay, great. How are you doing, Bob, and, let's enter into this conversation, and 2-1-1 backs out. And it's worked beautifully. And clients have continued to feel supported in that.

Sometimes the smallest part of the trauma language is about a significance to small things. And sometimes the how we do stuff is a replication of the system harm that that person has already felt. When you've experienced severe system harm and I think of an individual that I was just speaking to not too long ago. Our organization is involved in the Gambling Support and Tobacco Free Network. We run those after hours, help lines for McKesson and I think of the story of a client who a call dropped. And a call dropped due to technology, but that client's perception of that call dropping was that the worker did not feel that what he was saying was interesting enough.

So you have to think of a person's perspective. If they have lived through pretty systemic system harm then their experience within systems is they are hypervigilant to the care that they are getting in terms of those systems. And so the tone of voice from the navigator to our social worker, the fact that the navigator stays on until our social worker picks it up, the smallest things are hugely important to the care that that male or the person who identifies as being male feels.

The social worker engages in really what's called "brief solution focused work". So you have ... typically, the call is about 30 minutes. And we used a 30-minute timeframe based on

kind of research and evidence around other help lines and about ... it's not meant to ... it's not deep therapy work. It's not meant to unpack stuff. It's really meant to be quite goal oriented. You're experiencing duress in this moment. What are some tangible things that we can do? What are some of your response strategies that you've learned throughout your life that might still be useful to you right now? And how can we make you feel slightly better and slightly more balanced by the time you hang up this call?

And by "balanced" and "slightly better", I'm also paying attention to any time we can help a citizen of Nova Scotia; in particular, males or people who identify as being males, feel more balanced and more grounded and less in duress, the more we increase safety for women and children and people who need to be provided safety for, any other marginalized population. I'm very aware of the ebb and flow of those two things.

So our social workers are constantly assessing safety on those calls and they'll assess safety based on what the person is saying. They'll assess safety based on the tone of voice and the micro-cues. Telephone-based work is fascinating work because the level of concentration it takes from our workers to really and truly ... you don't have the visual. You don't have

the body language in the same way that you have the face-to-face. But the men's response across the province into this line has been overwhelming. So I just checked the stats. We've had over 1600 calls in the year since we launched. So the whole view that ...

Q. That's 1600 calls that actually get to the Men's Help Line?

A. Yeah, yeah. Oh, yeah. Yeah. So we need to debunk the stories of men don't access care and things aren't necessary and, you know, men can't process emotions. We need to debunk all those because the reality is that we've created something that is being used every single day.

I did a quick stat yesterday or the other day to prep for this and there's four segments to the day. There's the morning, the afternoon, the evening, and the night. Because when we started it and when I say "yes" then I turn to my beautifully brilliant leadership team and say, Okay, how are we going to create this? I need you guys to do all the detailed stuff.

We didn't even have staff. We didn't know whether we needed five people, whether we needed one person. So we started out with one social worker on every shift. We now have two because the Province has come back about three months ago and

asked us to launch a women's help line and an all-genders help line. So now there's access to two social workers. But the point was was that we had no idea how busy it was going to be. But, for me, it's a resounding success. If we've had 1600 calls ... and in the year since we've launched with minimal public awareness campaigns. And you mentioned that ... and a part of me, as an executive director, knows that we need to promote the service and a part of me is terrified by the thought of promoting the service all at the exact same time. And the Province did a soft launch with the Men's Help Line. And you have to think, too, we were in the middle of the pandemic. So what does a launch look like?

Q. "Soft launch" meaning quieter or ...

A. Meaning it was put out through government websites and we used collaborative tables based on another one of the Inquiries the Province ... Commissioner Nunn recommended collaborative tables exist in communities. And so we've been quite an intimate and leader partner in those collaborative tables. So we put it out amongst those knowledge holders.

But a soft launch isn't ... there's still lots of room for further promotion. We appreciated the soft launch only because when you're starting something new, we needed to go slow and

steady before we could figure out, I mean is it going to be responded to? Are people going to call? But then how do ... making sure we had the appropriate resources for staffing ... you kind of take a stab in the dark. But both 2-1-1, I think I'm speaking for them, and Family Services and the Men's Help Line and Women's Help Line and All Genders Help Line would say that we certainly can do a lot more public awareness around the access to those.

Q. And I think you had said a moment ago you check the four quadrants of the day. Were the calls ...

A. Right. Sorry. Yes. They're pretty equal. The highest percentage is in the afternoon, but only minimally. So it was fascinating because, again, if you don't touch base on what you think you know then you're just filled with assumptions and we just go blindly on. So it was important to realize that all four quadrants are being equally accessed. So when you think about systems and you think about how we provide service, and our belief as a worker that 8:30 to 4:30 is the glorious magic system, it's not the case. Because we have just as many guys accessing evenings and overnights as we do mornings and afternoons.

Q. So if ... you're talking, it seems, largely about

emotional regulation and those types of issues when somebody calls. Are there other things that ... what else can the Men's Help Line help somebody with?

A. Well, you name it and somebody will bring it ... a guy has brought it forward. And, by that, I mean you can't separate out your emotional state based on what's happening in your life. So the stories come in with, I've just lost my job, my girlfriend has just broken up with me, I've lost my child. That's what comes in. They're not using that language around, I'm hoping to learn emotional regulation.

Q. Sure.

A. I'm hoping to emotionally regulate in a different way. And I'm not making light of it. It's just language is so important that we ... yeah. And, professionals, we use language that often citizens don't have. And so our workers hear what ... the whole point of this, our workers hear what their situation is.

We don't need the person to unpack all the details of that situation. We just need to know that this ... what we need to hear in their voice is that something has happened in this person's life that is causing them to have feelings that are larger than they can handle in that given moment.

And then we move into ... so you think about a 30-minute call. I think about it as kind of divided into three sections. The first part is really about that relationship building. And you think about relationship building, you literally have about ten minutes to establish that relationship. So you have to really listen to what the person is saying, what's important to them.

Part of the trauma language in terms of the community version of trauma language is really supporting self-determination. So the kind of ... if you take it from an expert position is an expert will decide on what's important to a person and what they should work on, when you're supporting self-determination and you're relationship building with a guy on a help line, it's really what is it that is most urgent for them in this given moment.

So they've just lost a job. Okay. Well, the loss of the job, Where are you right now? Like are you somewhere safe? Are you indoors, if we're in a storm. When was the last time you ate? Can you get a drink of water? Like we're trying to pay attention ... we're not solving ... the goal is not to solve the fact that they just lost a job. The goal is to help that person move to a slightly different emotional state within 30 minutes

than they were when they left the call. And when you move somebody ... when you help support somebody to a different emotional state, their ability to critically analyze and use those brain functions then begins to return. That's all.

Q. So the guy who may have lost his job and is just ... his mind is going off in eight different directions ...

A. Exactly.

Q. ... and maybe that half hour with him to help him step back a bit and find a solution to his most immediate problem, for example, can help to emotionally regulate him?

(11:10)

A. Hundred percent. We like to think that somewhere in the world we've gotten to this place that we need more resources around the self-actualization work, like that real deep therapy work. And in my experience, particularly with the men and the people who identify as being male, there's a need for those services.

I mean I run a therapeutic organization and I'm saying that we need those highly specialized. What we also need is the real ground foundational-based social determinants of health conversation. So when somebody is in emotional distress, when was the last time they ate, when was the last time they slept,

do they have ... can they have a drink of water. When you pay attention to a whole person's body every time you move, or shift that a person makes, helps them in terms of their overall emotional control.

And so lots of those conversations and what we're receiving feedback from the men, which is important, on the line is 90 percent surveyed said that they would highly recommend to somebody else to call the line and that they have found it very useful.

Part of what they say is that they felt heard. In that moment, they felt heard. They didn't feel pushed into an educational program to make them something that they weren't ready to hear. They didn't feel diagnosed. They just felt heard. And second of all, that they felt supported as a human being.

Sometimes I think in society we've done a disservice to men because we've taken what we want them to be out of their actual bodies and their minds. They are human beings and so they need safety, they need heating, they need housing, they need food. They need all these things in order to feel secure.

We can't expect a certain level of behaviour unless they're cared for. They are active participants in the care-for, but

unless society cares for them at the foundational level ... so part of that work on the help line is really quite grounding questions. Where are you? What's happening right now? Who's around you?

Sometimes it's about moving a person out of a situation that is highly conflictual. Somebody is yelling at them in the background. Sometimes it's about removing them into a room where they can begin to collect their thoughts themselves and begin to become aware of what their feelings actually are. That's the kind of work that happens.

Q. Is the 30-minute timeframe is that evidence based?

A. Yes. It's something similar to like our ... the Gambling Support and the Tobacco Free, typically they're 30-minute calls. It's helpful ... some of the calls go over. But it's helpful to kind of put a bit of a boundary around what the calls are and what they're not. They're not meant to do deep dives therapeutically. They're not meant to be given a person's entire recap of a childhood.

Sometimes people feel that in order to be heard presently in their present state, you need to know everything that's happened to them in the past. What we're trying to say is by engaging authentically with them, we just need to know what's

happening to you right now in this moment. And in this moment, if we can just handle the moment that we've got in front of us, that may or may not come but right now we're just going to get you to a slightly different place. So 30 minutes is evidence based.

Q. If the social worker who's on the phone thinks that it is a more serious situation that might require, for example, 9-1-1 or DCS or ...

A. Yeah.

Q. ... what-have-you, are they trained to deal ...

A. Oh, yeah.

Q. ... with that and will they take those steps?

A. Yeah. They are, for sure. As workers, you're constantly assessing safety. So we have the guidelines of confidentiality around when we would involve another system. Every caller is engaged in those guidelines of confidentiality. And of course those are risk to self, risk to others, know if a child is being at risk, or subpoenaed by court.

And so that's articulated at the beginning of the call. And our workers are constantly assessing safety, tone of voice, things that they're talking about, history. And so the help line social workers can actually link in 9-1-1. And they're

also completely familiar with making referrals to Child Protection after-hours line.

Q. All right. So you said you've had 1600, roughly, calls over the last year. And do you see the Men's Help Line growing and ...

A. Yes, because that's 1600 calls without a huge publicity campaign so ...

Q. And is there publicity coming? Some of it today, I take it, but ...

A. Yeah. I'm aware ... yeah. I actually gave our team a heads-up, but yeah. It's important that citizens in Nova Scotia know the resources that are out there. It's also important that the resources have enough support that they can handle the actual need. Right? And, thirdly, it's important that the resources collectively support each other.

Q. Okay.

A. Yeah.

THE COURT: I was going to say, Mr. Murray, that normally we would take a mid-morning break and this may be just the right time to take that mid-morning break. All right? So perhaps 20 minutes or so?

A. Okay.

THE COURT: Give you an opportunity to stretch your legs and we'll come back at 11:35 or as close to that time as we can.

A. Okay.

THE COURT: Thank you.

A. Great.

COURT RECESSED (11:15 HRS)

COURT RESUMED (11:39 HRS)

THE COURT: Mr. Murray?

MR. MURRAY Thank you. Ms. MacDonald, before the break we were talking about the Men's Help Line and the access point through 2-1-1. That project, is that a fair way to characterize what's going on with the Men's Help Line?

A. Sure.

Q. That's been in place now for a year.

A. Yeah.

Q. Did you describe it as a pilot project or ...

A. I think that I would use the word "pilot project" because it was ... it is brand spanking new and it is the Department of Community Services and the Status of Women. Yeah, we're one year in for funding.

Q. Right.

A. And we've got a guarantee of funding for a little bit

longer. So I think there ... I wouldn't classify it as a core program yet. I think they're using as much of the evidence as they possibly can. They're wise. Government is wise. They're not going to fund something if nobody is using it. But the evidence is showing that it is used.

And there's this interesting synergy that's happening right now in the country. So as much as this was mobilized provincially, locally, out of the needs of community, I often say that community organizations like ourselves are like the emotional barometers of a community. You can always tell what the nature of the emotional state of a community is by the interesting cases or the complexity of the cases that are coming in. So, for example, our Glace Bay office gets a lot of pretty profound grief and, you know, Antigonish gets a lot of relationship type of requests.

So, anyways, the community organizations are like an emotional barometer. But to the help line, I know that we have funding for this coming year but I think they're waiting to see what else is ... if it's going to be useful, if the evidence is showing that it’s being used.

But, nationally, we have been involved with a University of Western prof, Dr. Katreena Scott. And I don't know all the

details because she's been involved in the help line and research around the help line, but from a federal perspective. And so my understanding is there's an intense and immense interest nationally for a national men's help line and that ... she has been parachuted into our local project. She mentioned at one time that early in the pandemic, nationally, the need for this was identified from all the provinces as needs were percolating up from community from men and those who identify as being men.

And so she had mentioned that provinces and territories were tasked with prioritizing the implementation of a help line. And she mentioned one time at a meeting that we were, to the best of her knowledge, the only province that had mobilized. And we weren't mobilizing it based on anything to do with federal infrastructure or the federal knowledge. We were literally mobilizing it because it became a need out of our local community and our local province.

But she's involved in our group and she's been involved in a lot of meetings. And we have another meeting with her shortly after the federal election. So there's something happening nationally about an interest in a line. And I think the national interest, based on what she's been saying, we just did

a joint interview with Citytv Toronto.

And when I listened to her part, she was talking about that domestic violence is, as a national issue, is they're looking at creative ways to get to support and understanding the support for men, and people who identify as being men, early on and support that is not time limited in terms of there's no constraints on how many times they can access the call and that it's timely and that it's easy to access is being viewed as a mechanism of potential safety for women and children.

So they're starting to nationally ... that was unbeknownst to us up until she joined our meeting, but there's something happening, which is always reassuring on some level that it's awful that we're at this place, but it's also reassuring that we are ahead of the game in a way in this province, that we have transformed and typical in Nova Scotians, if something needs to get done you just pick up the phone and you phone somebody.

And it was never even about money. I probably would have said "yes" at that call even if it hadn't have come with money attached. And my Board would have said, What are you doing? But we've mobilized something that the Feds are interested in, long story short, in the interest of that.

Q. So to your knowledge, and I appreciate you can't speak

for every province in the country, but Nova Scotia is one of the pioneers, I guess, of Men's Help Line?

A. Yes, she mentioned that.

Q. Okay.

A. Yes.

Q. All right.

A. Yes.

Q. And the interest federally and, again, you don't speak for the federal government, but ...

A. No.

Q. ... is it to fund, as far as you know, these types of projects in other provinces or to establish something federally?

A. I mean I'm thinking that that's what the goal is. I know that her research team has done a really deep dive into our line. They've done a really deep dive into the level of collaboration that actually needed to exist amongst government and community because that's the thing that's made this line so beautiful and so successful is that it was a true partnership between government and community.

Government didn't try to mobilize it itself. When government tries to do ... government ... we need government, as I said at the very beginning, we need government to do their

highly specialized things that they're mandated to do but we also desperately need community because community ... people respond to community in a very different way. So the beautiful thing about the help line is it's community delivered but it's government funded.

THE COURT: Mr. Murray, I'm just going to dive in.

MR. MURRAY Sure.

MS. MACDONALD Okay.

THE COURT: I'm going to ask just a couple of questions while we're still on this topic.

MS. MACDONALD Okay.

EXAMINATION BY THE COURT

(11:45)

THE COURT: So when I was just doing a little background work myself, I had a look and I saw a document. And it had the Western University's logo on it. It was a document that was entitled **Centre for Research and Education on Violence Against Women and Children.** The heading was, "Research on the Nova Scotia Men's Help Line". And I'm going to read just a little piece of it. It said this:

> The Centre for Research and Education on

Violence Against Women and Children at Western University is working with the Government of Nova Scotia and its partners to study the implementation of Nova Scotia Men's Help Line pilot. Together with Professor Diane Crocker, Saint Mary's University, and Standing Together, an initiative in Nova Scotia dedicated to disrupting harmful cycles of domestic violence, this research will examine the help line's challenges and successes including the experiences of line responders and project partners. The Men's Help Line evaluation working group will work together to examine various aspects of the line's performance, including looking at call volumes, statistics, and client needs assessments.

Are you engaged in any of that process?

A. Yeah. I'm in that process.

Q. You're in that process? So they have an evaluation working group?

A. They do.

Q. You're part of that?

A. Yes.

Q. Okay. And who else is involved in that evaluation working group?

A. So Natalie Downey, who is with Department of Community Services, Prevention and Early Intervention, and Heather Ternoway from the Status of Women. And I don't think Diane's ever been there from ... but, anyways. Dr. Scott, who is from the University of Western, and she has two co-research people. I can't remember what their names are.

Q. One of those would be Professor Crocker?

A. No.

Q. No? Diane Crocker?

A I know Professor Crocker because from our SHIFT grant I was involved in research with her from our SHIFT grant.

Q. Yes.

A. So I know who ... she's been behind the scenes but not in that working group. And then the executive director of 2-1-1 and/or because they've had an executive director change, one of their directors, James Robertson. So that's the working group.

Q. So is this kind of group’s been formulated out of the

federal interest or ...

A. Well, that's ... I ... no. The working group existed. The Nova Scotian sections of the working group existed. In order to mobilize the line, we came together. So we're the original working group, the DCS, the Status of Women, the 2-1-1, and myself, we are the core ...

Q. So that's all ... that's been in place.

A. That's already.

Q. Yeah.

A. The federal ... the addition of Dr. Scott came partway through the process. We had already launched the line when she joined our group.

Q. And do they ... did the research group ... has it produced any documented statistics/results? Are they available?

A. Yeah. I was wondering if you were going to ask that. I think the best ... I don't have a copy of that. So Dr. Scott produced something and then that was going to be approved through the ministerial sections of Department of Community Services. So I would ask ... you would need to raise that higher than me to ask if you can get access, which I'm sure you can, to the final research. It's not something that's been made public yet, to the best of my knowledge.

Q. But it's been compiled.

A. It has ... yes, a hundred percent.

Q. It's compiled and it's sitting on a ...

A. It's sitting somewhere.

Q. Some ... on somebody's desk someplace.

A. Yes. Yeah. Yeah.

Q. You think. Okay.

A. Yes. Now that's the research that Dr. Scott did. There's also the local research that the Status of Women and the Department of Community Services ... because they're also collecting data around the line. Right? So ... yeah. But there is a report of some sort produced by Dr. Scott.

Q. Okay.

A. Yeah.

THE COURT: Thank you. Mr. Murray?

DIRECT EXAMINATION (Cont'd.)

(11:49)

MR. MURRAY: Obviously, much will depend on perhaps the outcome of that and what's viewed as the success of the Men's Help Line.

A. Yeah.

Q. But from your perspective, where would you like to see it go? Well, would you like to see the service expanded, continued as-is?

(11:50)

A. Continued ... the minimum would be continue. The second piece would be to continue, that we're a very robust working group and continue to meet as a working group and continue to figure out what else we need to do, whether it's expansion, whether it's more promotion, whether or not ... I don't know what else we need to do yet but that's a very collaborative group.

I'm aware of the federal interest but, at the same time, that is not what's driving this line. This line is for the citizens of Nova Scotia. And certainly I will make myself available, as I have, to the working group in terms of lending support to the federal initiative, but the federal layer of either grants or interest is always just another layer that you work through.

We don't have a strong as of a collaborative relationship with the federal government. We don't get any ... we've never received ... well, I better ... no, I don't know about the history, but currently we are not receiving any federal funding.

So I'm not as familiar with those relationships and those collaborations. I just know that she's present at our working group for sure.

I will just add, I think that the help line, in its true nature and the fact that the Status of Women are involved and truly trying to figure out what are the help-seeking behaviours of men and people that identify as being male. I think that that is absolutely crucial at this point in our province's place in terms of its health delivery and that those collaborations between government and community ... I always say we can create beautiful things if we do it together but not if we work in silence, we can't.

Q. All right. We've talked a lot about the services that Family Services provide and, to some extent, about where you'd like to go. Are there other services that you see could benefit men, men in crisis, families? And, in particular, obviously, our term of reference relates to domestic violence ...

A. Yes. Of course.

Q. To help prevent domestic violence, to make families healthier, make men healthier.

A. Absolutely. So our therapeutic services that funding to engage in therapeutic services comes from Department of

Community Services, most of it, although the rest comes from those social enterprises, contracts and so we get direct referrals from Child Protection and from Income Assistance. And the understanding and kind of goal is to provide therapeutic supports in a family context to families involved in that particular government department.

That being said, obviously there's all kinds of community people who aren't involved in Department of Community Services who land on our doorstep and seek help. And so future work is to figure out how we further partner with Mental Health. Mental Health ... and I just was in ... Heather Ternoway and I were just invited to represent the Men's Help Line at the Mental Health Steering Committee and I said to that Mental Health Steering Committee that we need to collectively, as a province own the well-being of the citizens of Nova Scotia and not think that mental health owns the Mental Health Services of the province.

We need Mental Health to provide the structured, highly intensive services that they offer, but we also really need them to lean into community and to figure out where we show up and what knowledge do we have. So that, moving forward, is a pretty substantial piece of work that I'm hoping to get to.

The other piece is that our therapeutic services are only offered from New Glasgow. It's part of our historical geographical region. So I'm hoping, with partnerships with government, we can continue to figure out what are the families' needs in other parts of the Province, right, so Family Service of Western, like I said, we all have a core kind of foundational belief and they're very, very highly active in housing and the need for housing in that area. But if you're a family living in Windsor and you want family counselling or you want couple counselling, where do you go? And so you're often left with trying to navigate the private practitioner world which is you need access to health benefits or you need access to financial aid in order to access the private practitioner.

So my goal ... I've always dreamed this coordinated access network where people are engaged in family and couple work and that can be done under kind of a family service lens, that it won't matter if you live in Yarmouth or you live in Windsor or you live in Canso or you live north of Smokey, that you can get access to this relationship-based counselling when you need it and so that's what we're trying to mobilize. When I say we're province-wide now, we are with the help line, we are with our Families Plus, we are with our clinical consultant network, but

we aren't with our therapeutic services. And so that's movement that I'm hoping that we'll make. There's a desperate need.

When we did a file scan many years ago of the guys who had access to Men's Health Centre, 80 percent of the men who had come through our door were there for some sort of relationship issue. So it's so important for us to realize that men, and people who identify as being male, we need to pay attention to the social context of their lives.

And if we're truly interested in creating safety, then we will do that within a relationship-based context. The individual-focused work is important but it cannot be done in isolation of the context of the relationship-based work, too.

Q. So the opportunity for more access for ...

A. A hundred percent.

Q. ... that type of counseling province wide?

A. Yes.

Q. How do you see that happening?

A. Yeah. That's a great question. I don't know if I have the answers to that completely. Well, that would require some funding. That would require a recognition that the couple and the family work was intimately involved in the overall well-being of families. Right now, the family-centered and couple-

centered work is really quite embedded in Department of Community Services especially childhood and early intervention.

All of their programming is about that family relationship-based work. They're funding parenting journey programs. They're funding Families Plus, which is that, you know, intensive family based. So they have this kind of family holistic lens. And I think the only way we're going to mobilize it is if other government departments, particularly Health, can also embrace more of a family lens or lean into community to embrace the family lens and less about just the individual.

We need the highly specialized Tier 5 psychiatrist to be dealing with the individual. I get that and I understand that. But long before that individual gets to need a psychiatrist, they are in and out of multiple relationships in their lives. And some of those relationships are positive and hope building and some of those relationships are devastating and a person needs a place, men. And then people who identify as being male need a place to unpack those things and learn strategies and new tools in order to help them navigate the world.

One of the psycho-educational programs we run is Cooperative Parenting. The number of people who move through relationships, particularly recently, like in the last ten years

and relationships are a little more fluid and people are living very complex lives and co-parenting children. And grandparents are raising children. And people need to unpack the complexities of how to be a good co-parent.

So just because an intimate partner relationship ends or is about to end, a person probably needs support in moving forward through that loss of that intimate partner relationship and maintaining their role like, for example, as a dad.

The reason I'm saying how important that is is because any time you can pay attention to and put significance of a person's actions to the roles that are important to them. The Men's Health Centre pays a lot of attention to roles. So if I have a guy sitting in front of me and they're a dad and they want to talk about the ... I always talk about, What role does being a dad play in your life?

If you lean into the roles that are important to a person, whether it's their racial identity or their culture or their role of being a dad, those are all safety measures. The more you can help a person move out of an intimate partner relationship but stay connected to his kids, the kids are often a leveling safety factor. Their role as a dad ... instead of ... the old language is you just wait for somebody to do

something and then you implement the program.

But programs like Cooperative Parenting are helping people transition through those hard relationship losses in their life but maintaining the important connections that they do have.

Q. So I guess at the end of the day, more opportunities for that ...

A. Yes. That ... definitely.

Q. That type of ...

A. Definitely.

Q. When we had spoken to you, you had I think mentioned the importance of reaching younger men and boys.

A. Yes.

Q. And are there ... is there programming in that?

(12:00)

A. We tend to fall a little bit short yet on that, but there has been unbelievable movement from the last Inquiry when Commissioner Nunn ... one of the 75 recommendations or 76 that he made was further integration and engagement in the school system. And so I think of SchoolsPlus as one of the beautiful programs that came out of that last Inquiry, which is why I'm so hopeful with this Inquiry, because in our experience wonder system changes have occurred with other Inquiries in the

province that we've been involved in.

And so SchoolsPlus is a program that is implemented in the schools, I think as of shortly ... like probably in the next couple of months. I think it's going to be in every single school across the province. It's one of the fastest moving programs that I've ever seen, funded through Department of Education, of a recommendation of the Nunn Inquiry. And it was about increasing social and emotional connection to schools. Because what they realized was when kids feel disengaged from a school then it increases their risk for harm outside of school. And so SchoolsPlus, some are social workers, some are not social workers but they're actively involved in the social and emotional well-being of kids.

So they're doing ... in Antigonish, for example, we helped ... through one of the SHIFT grants we helped fund a bike program and the bike program we bought a shed and we put it up at the junior school and we bought bikes and helmets and everything else, knowing that if the kids at ... SchoolsPlus locally are working with, if you get them out and you can do an activity with them and you can have informal conversations - they're not meant to be deep therapy work - then you place that kid back into the school and they're feeling slightly better

about themselves, slightly better about their world around them and then that will have a positive repercussion in their life.

So there's lots of great things already happening around the social and emotional well-being and understanding that mental health doesn't need to own all that, that lots of other departments are very interested.

Where we're falling still a little bit short ... and in this area we're lucky because we have the Health Relationships for Youth which was a program started by the Women's Resource Centre and it's run in, I think, the high schools. Again, I don't want to speak on their behalf but that's been a great program that talks early on to kids about their relationships and about what is a healthy relationship and the need to be okay as an individual but also okay as a couple. That there's relationship health and there's individual health.

But when I say "more information" I keep thinking what are the opportunities in high school, in particular, when developmentally appropriate conversations can be had, and is there a way to have developmentally appropriate conversations with particularly men and boys during that junior high and high school when they're just emerging and their potential needs for seeking help are ... they're just beginning to figure that out.

Our systems are ... they try to be well being and they're well intentioned but often we use an old kind of historical view that men and boys are potential perpetrators and women and children are potential victims. And we need to move to a place of understanding that women and children are at higher risk for sure of domestic violence and family violence and we need the highly specialized programs but that we also need to invite boys early on into their own exploration of their own emotional work.

Moe Green has done a lot of work in the province. He's ... he was originally with Public Health and he has partnered with a prof from St. FX and myself and we've begun to write curriculum around authentic engagement with boys around the Grade 7 and Grade 8 level that we're hoping to roll out across the province, where it gives boys an opportunity to show up without a language of a potential perpetrator in waiting, not that, but truly as a human being to begin to explore their own emotions and what their own needs and wants are.

The more we can have conversations with boys early on that they're going to have needs, they're going to have wants, they're going to have ... and how do you get those met and what are your help-seeking behaviours the safer we'll all be when they're adults. Yeah.

Q. You could obviously talk about other needs and programs I suppose for quite some time, but I get a sense that the Help Line, in particular, is a big piece of ...

A. Mmm. It's key.

Q. Of the work that you're doing now ...

A. It's key.

Q. And want to continue doing to help men be healthy and families be healthy and to reduce domestic violence.

A. Mm-hmm. And really, really about the need for system transformation. We have too much knowledge behind us now to understand that an 8:30 to 4:30 system is going to be all that's necessary. And so the Help Line has shown that if you create something and you can access it in a timely fashion and people can feel supported that they will access it. And that ... yeah, that 24/7 perspective has been quite transformative for us an organization.

Q. I'm going to shift gears a little bit now.

A. Okay.

Q. Your organization did have some contact with Lionel Desmond.

A. We did, mm-hmm.

Q. Okay. And we have a couple of documents that I think

are marked as Exhibit 313 ...

EXHIBIT P-000313 - INTAKE SUMMARY

A. Okay.

Q. ... which we are going to bring up on the screen.

THE COURT: Are there hard copies as well?

THE CLERK: There's hard copies on the table.

A. It's okay, yeah.

THE COURT: Are you all right ...

A. I can see, but thank you.

THE COURT: ... with the screen? Right, okay.

A. You can see my glasses.

THE COURT: Thank you.

A. I got it.

MR. MURRAY: So the document that ... I think it's a two-page document ...

A. It is, yeah.

Q. ... and the beginning of it is "Intake Summary".

A. Mm-hmm.

Q. I know you're familiar with both pages of this document.

A. I am.

Q. First of all, can you tell us what the document is?

A. Sure. It's a document that was produced by our internal data management system and the data management system is called Penelope, it's run by Athena Software, and it has given our organization the ability to provide the cross-provincial work that we do but stay connected.

Up until the development of this or the implementation of this software we were paper filed and we were individual office-based and so we would never have been able to do the quantity of care and support that we actually provide now without this system. So that's what it is, it's a printed off page from that system.

Q. So your electronic data management system is something that all of your offices use?

A. We are all linked. So what it also does, is a long time ago we kind of took our ... we were a more robust leadership team and we deconstructed the leadership team and we put the funding into front-line work. And so in order to do that we are a very tiny leadership team of four people and this data management system has been key for us because our therapeutic support supervisor who supervises this program is actually based in Antigonish but she has workers all over the province. And because of this system, she's able to keep a very

close eye on files, she can receive the reports and the risk assessments as she needs them, and so, yeah, the implementation of this was key for us.

Q. So I guess in simplest terms if someone calls or if a client calls or a member of the public who has a question and wants to make an appointment, let's say, that type of thing, will there be an entry in your data management system?

A. Yeah. Not if ... not just a general call for information. An entry isn't made into the data management system until the conversation with an admin and the person is willing to enter into therapy or expresses an interest to enter into therapy, that's when a data entry is made.

Q. Okay. Somebody who may become a client?

A. Exactly. Exactly, yeah. We have lots of calls of information, yeah, about ... yeah, but we don't record those.

Q. And if we just go down this page a bit, we see here we have a section of the first page of this document that says "Case Profile" and there's a case ID number and a date saying that it was created on December 9th, 2016.

A. Yeah.

Q. Okay. And then obviously below that we see Lionel and Shanna Desmond's names there.

A. Mm-hmm. Yeah.

Q. So can you indicate ... obviously there was some contact from the Desmond Family ... from Lionel or Shanna or both.

A. Mm-hmm.

Q. And is this the ... first of all, the information that would be entered into this system when somebody is referred or calls?

A. Yeah. So that's a case framework. And so what happen ... what ... to deal with ... dive into the details is that my understanding was Lionel called and our admin in the New Glasgow office, in order to ... we have four admin for the whole organization and we have a 1-800 number and we have local numbers but they cover off for each other and so the call came in to Antigonish but the calls were transferred to New Glasgow and so our New Glasgow admin answered the phone. And based on what this is saying she would have had a conversation with Mr. Desmond and he requested or he was thinking about entering into couple Counseling which is why the intimate partner, the wife's name, Mrs. Desmond, was put in there.

Q. So can I just ask is ...

A. Yeah.

Q. ... PRI- ... P-R-I-M ...

A. Is the primary ... is the person who's phoned.

Q. Okay.

A. Yeah.

Q. All right. So it was Lionel who called ...

A. Yeah. Yeah.

Q. ... but it was couples Counseling and he and Shanna's names are both there and their dates of birth it would appear?

A. Yeah. We just ask for that information. And so then it just what happens is the admin who answered the phone, she'll put the data into the case and she'll book them with a first call intervention. The wording is "Intake" on there, that's a system word. We actually call it first call intervention. And the reason we changed the terminology was because it is so much more than an intake.

The first call intervention is with a social worker and the social worker was Ann Delynn MacDougall. And that first call intervention, really, is like a beginning session for these individuals or for this individual, and that was going to be booked ... they were given an appointment for that intake on ... well, it was January 16th or somewhere. I don't know if it says it on that one but they were given an appointment for a first

call intervention in January.

(12:10)

Q. Yeah. I think if we go to the bottom of that page that it's shown there.

A. It's somewhere on that page. Yeah, okay. Yeah, there it is.

Q. It says January 16th?

A. Yeah, at 11.

Q. Okay. So Lionel called on December 9th and spoke to the admin?

A. Yeah.

Q. Okay.

A. Yeah.

Q. And maybe we can just go up just a touch there on the page that we're on because I think there's ... under "Notes" we see "December 9th, 2016. Lionel called to discuss the possibility of couple's Counseling."

A. Yeah. Yeah.

Q. Okay. And then "DM" that's one of your administrative assistants is it?

A. Admin. It is, yeah, in New Glasgow.

Q. Okay.

A. Yeah.

Q. So when he called the administrative assistant who speaks to him could be physically in any location?

A. Yes.

Q. Okay. And in this case the admin was in New Glasgow you said?

A. Correct. Yeah.

Q. Okay. All right.

A. We pair the offices, so New Glasgow and Antigonish are partner offices and Glace Bay and Sydney are partner offices. They're the offices with the bricks and mortar and admin staffing.

Q. Right.

A. And so if the admin is off in Antigonish the calls are forwarded to New Glasgow. So I have a feeling that Mr. Desmond would have called the local Antigonish office and just because the calls are forwarded that admin in New Glasgow answered it.

Q. Okay. And just going down the page again, if you could, just to the bottom there, the appointment was scheduled then I take it for January 16th, 2017 at 11 a.m.?

A. Correct, yeah.

Q. It says "Duration - 45 minutes". Is that what the

anticipated duration of the first appointment would be?

A. Yeah. For the first call intervention, yeah.

Q. Okay.

A. Yeah.

Q. And the site was going to be Sydney. So did that mean that they would have had to go to Sydney for the Counseling?

A. No, this is just the system. It just means that's where that primary worker is based.

Q. Okay.

A. So that intake social worker is based in Sydney, but the intakes for the first call interventions are almost always by phone and then ... but a person can request a face-to-face intake if they need to. But this one that's ... the site is the worker not where it's going to occur. It just means she's in Sydney.

Q. And the appointment was with or was intended to be with Ann Delynn MacDougall?

A. Yeah.

Q. And who is Ms. MacDougall?

A. She's a social worker.

Q. With your ...

A. She was. She's now with a collaborative health

practice, like she's ...

Q. Okay.

A. ... one of the workers that Health has ...

Q. Has stolen from you?

A. I wasn't going to use the word "stolen", I was going to come up with something positive, but anyways, yes.

Q. Okay.

A. Yes.

Q. So Ms. McDougall was going to be doing the session. So the request was for couples counseling, would there have been more information taken or would that have just been the general kind of idea what we're looking for, an appointment made and then the worker would have gone from there?

A. Right, yeah. You'll see our admin's language was ... if you flip it back up, she writes in the report "is exploring couple Counseling". The decision of what the modality of Counseling is is made with the social worker and the client, it's not made by the admin. So the admin ... the notes are made for as kind of an ongoing communication. So when the intake worker ... when the social worker picks up the file she can say okay, this is what the individual is looking for.

The social worker, if that first call intervention would

have proceeded into January conversations, there is an actual intake form or first call intervention form. Couple Counseling, they're going to have conversations around what's the current status of the couple, are you living together, are you not living together. The social worker would then need to engage in a conversation with the other person that's involved in the couple.

Lots of times people when they are beginning to experience couple duress is when they call and ask for couple Counseling. Couple Counseling is a very intense work and people sometimes have a view that couple Counseling is meant to preserve the relationship and it's often the work that occurs to actually appropriately dissolve the relationship and move them into a co-parent ... if they have children, move them into a co-parenting situation.

The fact that Mr. Desmond called and asked for couple Counseling, that's a very common language that people have, but if they had have made it through the first call intervention it would have been fleshed out whether or not that was actually something that both parties were willing and interested in. Or maybe it would have been if the relationship had have gotten to the point by January that it had ended maybe it would have been

more appropriate to cooperative parenting. So how are you going both maintain if you have a child involved. How are you both going to continue to love and care for this child but not as intimate partners. So the kind of the fleshing out really occurs at the first call intervention.

Q. Okay. So the social worker would kind of make that determination as she spoke with both partners?

A. Exactly, yeah.

Q. And could that have led to other sessions?

A. Oh yeah.

Q. In other words, there's one session set for 45 minutes.

A. Yes, absolutely. That's ... I would ... I don't know the stats for this, our therapeutic support supervisor could say for sure, but when you involve yourself in a first call intervention, I would say almost a hundred percent you're moving into another session. It's just what is that work. Is it individual, is it family, is it couple, is it programming, what exactly is it, that's part of that conversation.

Q. Okay.

A. I was going to say just to highlight another point about domestic violence and couple's Counseling. There's a lot

of research around the need for the domestic violence work to be embedded in reparative work in relationship-based work. But couple's Counseling also requires intense emotional work and so risk for increased domestic violence can occur from couple Counseling.

Q. Right.

A. And so our social workers are very skilled and especially the first call intervention. If an individual is already involved in a domestic violence program of sorts, we would most likely say that couple Counseling is not at this time something that we're going to proceed with but we would do individual. And then once the individual moved through the domestic violence Counseling or that more intensive service then we might look back to couple Counseling.

But it's important to know that the couple Counseling, just because somebody requests couple Counseling it's not something that everybody participates in.

Q. Okay. All right.

A. Yeah.

Q. And presumably the worker would make those assessments?

A. Yes. Yes. Yes. And ongoing assessments, right?

Q. When she met with him.

A. Ongoing. The same as if a therapist receives a couple and you begin within that ongoing therapy, you've got a couple and you can see that there are ... obviously you're in couple Counseling because there's relationship issues but there is the potential for violence or safety then the very first thing that that therapist is going to do is to shut down the couple Counseling and begin the individual work for each person and seek out whatever other resources are appropriate.

Q. Okay. Where would that first ... had it happened, where would that first Counseling have taken place?

A. It would have occurred in Antigonish.

Q. All right.

A. That's ... well, I think that's where their ... it doesn't say, but the fact that they're calling Antigonish is where Mr. Desmond ends up calling, I'm assuming that's the closest office to them.

Q. Right. So it would have been at the closest office for them?

A. Yeah.

Q. Okay. And you had said at the beginning of your evidence that you originally had done some work in Guysborough.

A. Yes.

Q. Do any of your sessions take place in Guysborough now?

A. Not physically, no.

Q. Not physically? It's only telehealth or Zoom-type meetings?

A. Yeah.

Q. Is there any ... is that because the ... is that purely pandemic related? Is that because the virtual counseling has sort of supplanted in-person Counseling for some rural areas or ...

A. No, that's about funding.

Q. Funding.

A. That's about trying to figure out where we can place ... where ... yeah, that's about using the resources that we have. There are a lot of communities that we would love to have workers in, especially doing this kind of work, but that's a funding.

Q. Right.

A. Yeah.

Q. Okay. All right. The ...

A. I was just going to add.

Q. Sure.

A. When I was there my understanding, because I wasn't a decision-maker back then, but when I was there it was a special pocket of funding that was used to provide me as a full-time worker in that community.

Q. Right.

A. It wasn't an ongoing thing.

Q. Okay. And when a person calls for Counseling, is the first session ... again, perhaps pandemic aside, is it anticipated that that will be in-person or can ...

A. Oh yes.

Q. ... a person ask for a virtual meeting or ...

A. Pre-pandemic we only had face-to-face.

Q. Right.

A. Pre-pandemic we didn't even have the knowledge or the know-how to do anything else but, and we had the belief that face-to-face was better than. Now it's a conversation that you have based on the logistics, based on the person's situation. If a person is living with severe poverty then obviously a telehealth situation might be better than unrealistically expecting travel.

One thing I was going to say that as all those years that I was delivering the Respectful Relationships program, the immense

system difficulty of those guys trying to get to that group was huge. So especially traveling from Canso or from outside, like Louisdale or Richmond County, they would either have to pay somebody, find 20 bucks and pay a community member to drive them to the group because the group was mandated. They had to participate in the group based on probation.

But the probation officer and I talked for so many years in trying to figure out how could we mobilize these programs to cause less stress. You've got an individual who's involved in the Justice system, involved in domestic violence, recognized it, coming to programming but is either taking time off work. Many of the participants in the Respectful Relationships work did not have paid leave.

So we ended up shifting the program to occur in the evening instead of during the day so that at least, for the majority of them, they wouldn't have to take time off work. We shifted it from late spring because we were negatively impacting the fishing people and the forestry people. They would say, I'm losing a day's pay to come to group. Like a day's pay in my family is going to increase my inability to emotionally regulate, going to cause more safety risks for my wife and children.

Anyway, we were trying to pay attention to all that, but the bottom line is now we have the choice of control over process. So you're asked: What's the way that you feel you can most engage in this, Zoom, telephone, face-to-face.

(12:20)

Q. Right.

A. And it doesn't need to stay. You can start with one and then you can move into another one if it's not working for you.

Q. Okay.

A. Yeah.

Q. So it's all about accessibility?

A. Exactly.

Q. So the appointment was made for January 16th, so it's about a month ... five weeks down the road.

A. Yeah.

Q. Is that about a typical wait for your shop or was Christmas in there? What was ...

A. Yeah, the December break was in there so, yeah, I would say that that's kind of normal, but the December break it's a bit of a ... like a 10-day slowdown in there so that would have had a factor in those particular dates too.

Q. Right. So then there's a second entry there, January 3rd, 2017, which obviously is a significant day for us.

A. It is, okay.

Q. And the entry this time is by MB, that's another administrative person in the office?

A. That's our Antigonish admin.

Q. Okay.

A. Yeah.

Q. So the call this time was to Antigonish?

A. Yeah.

Q. Okay. And after Mr. Desmond made contact with you first, with Family Services on December 9th, would any other contact with Family Services have been noted in the running file?

A. Yeah.

Q. He was considered a client at that point?

A. Yes. Yes, there would be a ... there's a service ... once a service starts or once a case is opened then if he had called back and asked for a change in the appointment or if ... then the notes would be in there. It's called a running note so that you can keep track of contact points, yes.

Q. Okay. So we can assume then safely that there really

wasn't any contact ...

A. No.

Q. ... between him and Family Services ...

A. To the best of my knowledge. Yeah.

Q. Between those two dates?

A. Yeah, that's correct.

Q. And, similarly, had Shanna contacted ...

A. Yeah.

Q. ... I appreciate she wasn't primary but she's listed as coming for couple's Counseling ...

A. Mm-hmm.

Q. Would that have been noted?

A. Yes. And she could have called and asked for individual Counseling and she could have ... you know, she could have gone that route. But yes, if we had have any contact with anyone that's listed within our data management system there's a note taken.

Q. Okay. And I didn't ask you but when the original call was made for couples Counseling is there a question asked about whether the spouse or partner wants to do it or is consenting or is it sometimes one partner saying I want to set this up and I don't know whether my partner is going to come or not but ...

A. It's not asked by the admin. That's what's flushed out with the social worker. It is often one person in the couple really beginning to reach out and understand a person begins to see the unraveling of their relationship and the transition of their relationship from an intimate partner to something else and they are reaching out to whatever resources they possibly can in the hopes to maintain something in that relationship. It's very common that one member of the relationship call and ask for couples Counseling. It's very common that by the time you get to the first call intervention that the social worker becomes very aware that the other member has no interest whatsoever in the couple's Counseling.

Q. Right.

A. Very common.

Q. All right. So the entry from January 3rd, 2017 it says: "Call from Lionel stating that he will be coming for therapy himself. He would like to have his partner join him later if things work out. Lionel is still living at same address but states he is trying to get a place in Antigonish. MB."

A. Yeah.

Q. The administrative person who wrote this, the

expectation is that how much of the conversation would be recorded in the running notes?

A. That's a great question. We try to say to the admin involve enough information in the conversation that is useful, that you think will be useful to kind of do that warm transfer to the social worker. The social worker before the first call intervention is going to pull up these notes. They're going to look and see, okay, so, you know, Mr. Desmond called on December 9th, he's hoping for couple Counseling. He called again on the 1st was moved from couple's Counseling to individual.

The admin are ... we try to have a consistency with what the admin put into the notes in terms of they're not privy to any details, sometimes people give them those details, but that's not what's needed to be recorded. Just enough system stuff, enough information for the social worker to begin to build that knowledge about this individual and what they might need.

Q. Is each individual call recorded separately on a given day or ...

A. Typically, ideally, yes. Each time that we would receive a call from a person involved in our data management system it would be recorded. Sometimes, like in this case, it

looks ... my understanding is the January 3rd got collapsed because we had ... this is ... the call from Mr. Desmond occurred to my understanding over lunch, it was a voicemail, and our admin actually called back to Mr. Desmond, which is the longer conversation, but it doesn't record that. It's not articulated that way in that note. And I only know that because I was in the office that day and so I was right there during the call.

And so ... but ideally ... it's an admin error. Ideally, we want the admin to record not only this but the times of the calls. So a lot has changed in our ... I look back to this, this was 2017, we've done a lot of work as an organization to tighten up around the expectations of what's actually in a note. They don't even sign them that way anymore now, they sign them with their full names. Anyways, all kinds of changes have occurred.

In terms of accuracy, and I don't mean about ... sometimes the system gets so tight that it's not even valuable anymore, but we needed to tighten things up. Because back here in 2017 each of the offices the admin was solely responsible for the files that were in that office. You fast forward to 2021 and the four admin are sharing the files that are across the entire

organization. And they're worker-based.

So our MB in Antigonish, she has workers that are in Sydney, she has workers that are in Halifax, she has workers that are in Antigonish, so we needed to tighten up what the expectations are of the notes and signing off and all that kind of stuff. So a lot of work has been done since this.

Q. And you said you were present in the office that day?

A. I was. It's a Men's Health Centre day, it was a Tuesday.

Q. Okay. So ... right, Tuesday.

A. Yeah, I was there.

EXHIBIT 000099B - EXTRACTION REPORT - PAGES 10-19

Q. So ... and just on the point you were making about this being a call and then a call in and then a call out, if we could bring up Exhibit 99B and page 12 we're going to go to and just zoom in right at the top there.

So this is the log of outgoing calls from Lionel Desmond's phone which we have previously obtained and marked as an exhibit and there is a call outgoing to 1-902-863-2358, and I assume you're familiar with 863-2358?

A. Yeah, that's our Antigonish office.

Q. Okay. So a call went out to your office from his cell

phone and that was on the 3rd of January at 12:47 p.m., I guess it would be ...

A. Yeah.

Q. For a duration of 1 minute 5 seconds. Now if a person were to call to make an appointment or change an appointment, talk to an admin about those types of things it would be longer, I take it, than 1 minute and 5 seconds?

A. It would be. That's a voicemail is what that would be. That's a please call me back, I'm wanting to do something different, change my appointment or have decided not to come to Counseling. In the time frame of that that 12:47 on Tuesdays is the one day of the week that we try to maintain something of a lunch hour.

Q. Right.

A. So we try to sit down together as a team and eat something.

Q. Right.

A. And so we say the telephone can go to voicemail during. And I just know that because that's the only day of the week that I'm almost guaranteed to be in and so the fact that it was at 12:47 I'm thinking we were having lunch together.

EXHIBIT P-000099A - EXTRACTION REPORT - PAGES 1-6

Q. Right. Okay. And then if we could go to Exhibit 99A and page 5, in the middle, just down, there we go, so these are the incoming calls on January the 3rd. And the last incoming call or the second-to-last call we've heard evidence about on the 3rd of January we heard from that witness. The last call which was on January 3rd, 2017 at 1:54 for a duration of 6 minutes and 57 seconds, and it's from an unknown number.

Now when someone calls out of your office does your number show up or does it come as ...

A. No, that's what it shows up as is unknown.

Q. As "unknown"?

A. Yeah.

Q. Okay. And the duration of this call, 6 minutes and 57 seconds, that would be the timeframe consistent with what?

A. Consistent with somebody ... oh, I was just going to mention the reason it comes up as unknown is it's around safety. When you're calling in to a person's phone, not everyone in that person's life is aware that they're trying to access services and so we intentionally ... our lines are blocked. And there's a ... you know, there's a conversation around well does it increase safety to know that it's from Family Service or does it decrease safety. Our view is we need to make sure that we're

speaking to the person that we need to speak to without it being knowledge that we're calling. So anyways, that's why it's unknown.

Q. Right.

(12:30)

A. But, yeah, typically that's about average. When a person calls the admin certainly listen. The person wants to tell their story, they want to tell why they're calling. They want to be heard.

And also if the admin would have, as MB states in her notes, he was wanting to switch from couple Counseling to individual Counseling. So, you know, that's going to take some time to explain, not that we ... she, again, she's not going to have any say in or authority into saying, No, you can't do that. She's going to say, Yes, of course, you can talk to the intake worker, that should be fine, or the social worker. And so, yeah, that would take about that length of time to have that conversation, yeah.

Q. And I think we can be frank, you've spoken to Mary Bowman, who is MB, about this.

A. I have.

Q. And she did call back.

A. She did, yes.

Q. So the conversation, obviously it's seven minutes, so there would have been more conversation than just three lines, but from your understanding from being there that day and from speaking subsequently to Ms. Bowman, was there anything of concern in that call? Was there anything that, either that day or subsequently, that you all looked at and have raised any concerns?

A. No, certainly not, and I was present that day and my office is far away, I'm as far away from Mary as Allen and I are together right now. That call, we handle thousands and thousands of calls every year, Family Service does, and our admin are extremely skilled at slowing down the conversations and being able to de-escalate callers if they are becoming escalated. That call, Mr. Desmond was not in any way, shape or form escalated. It was a calm tone of voice, Mary says to me. It was just matter of fact. I don't need couple counselling anymore, not at this point, I want individual. Mary would have asked, Okay, I'm looking at my screen and is this address still the right address if we need to get ahold of you? Yes, I'm looking for a place in Antigonish but that's still my current address. There wasn't anything in that call or that tone that

made Mary, as she reports to me and as I saw that day, anything that she would have engaged in any other way. So by that I mean, if he had been under real duress or become more duressed on the phone, or if he had started out in real duress, it's very common for our admin to pull in whatever social worker happens to be in the office at that time, or therapist, and it would have been me, because I was sitting right there. And all that is is to use our academic skills to be able to help that person calm down and to figure out what else needs to happen.

First of all, most of the time our engagement with our system is different than engagement with the government system. So, typically, we get people that are calling in and they're under duress but as soon as they know that they can access care and get an appointment, then that typically tends to subside. Sometimes people present with a real level of aggression because they're used to system harm and they're used to not being heard. And so as soon as they experience a different experience with us, typically, most of the time, we can de-escalate people. But there wasn't anything in that call. She didn't act in any other way other than have a full-fledged conversation, change it to individual counselling, and make sure that his address was up to date, and then hung up.

Q. So the administrative assistants are trained, part of their training is that if somebody is in distress or there's something concerning about their presentation, they engage the social workers or counsellors or yourself.

A. Yeah. We are involved in reflective practice in our organization, which is part of the fact that every worker involved in our organization engages in individual and group reflective conversations. And so I'm the supervisor for our admin and once every two months, we sit down together and we talk about either rough patches that have occurred during work or it ebbs and flows into their personal stuff, personal stuff is getting in the way or coming into the office. And then once a week, with this admin team, and we talk about ... We can process and unpack difficult cases or complex cases and we can lend support to them. In our organization, we view the work of the admin of as equal importance to the work of a social worker. They are the first person in contact with our individuals and most of the time people are calling asking for our help on not their best days of their life. And so we need our admin to really embrace kind of a trauma-informed perspective, nonjudgmental, tone of voice. We spend a lot of time with them coaching them through how to be really authentically engaged on

the phone to some pretty highly complex situations.

Q. And maybe if we could bring 313 back up. So the request here, of course, is that he wants to change the counselling from couple's counselling to individual counselling.

A. Yeah.

Q. And you've touched on this a little bit, obviously.

A. Yeah.

Q. But is that unusual and is it any kind of a red flag, is it something that either an admin or a social worker might set off alarm bells?

A. No, it's not unusual, it's really common, really common. Lots of people set out with the thought that they're going to involve in couple counselling and then a matter of days or a matter of moments, move through and situations in their world, they come to the realization that the relationship is going to transition to a different stage and then they'll move into individual counselling. So that's really common. And also I said to you, too, that couple's counselling often isn't really about keeping couples together. It can be that but it's also about helping them transition into their new current state, which is as co-parents or separated individuals or whatever that complexity is. It doesn't raise a red flag. No, not to the

admin, it wouldn't raise a red flag. It would be probably part of the conversation that that social worker, that first call intervention person would be having with them. So I see that you started out as couple counselling and now you're looking for individual, can we talk a little bit about the status of that relationship. I can guarantee you it would have been one of her first questions.

Q. When he calls to change the appointment ...

A. The admin is not going to, no.

Q. There's no policy that the admin should come to you and say this guy's changing from couples to individual.

A. No. If his emotional state was under duress, he was calling like ... People have the right to move amongst modalities, right. And we understand people live in complex lives. There wasn't anything in his tone or anything that would have required any extra care from our end is how I listened to what Mary said. So if he had been in duress and he had been very extremely upset about the fact that he was verbalizing it to Mary the fact that it wasn't going to be able to be couple counselling, I can guarantee you she would have moved into one of those other levers and engaged myself who was sitting right there.

THE COURT: Ms. MacDonald, I'm going to stop you.

A. Yes.

THE COURT: Just a quick question. Don't lose your spot, Mr. Murray. The note on December the 9th, it says couple's counselling and the note on January the 3rd talks about he'll be coming in for therapy himself. So the words got changed from counselling to therapy. Would that be language he used, would Ms. Bowman put in his words or would that be ...

A. Oh, that's a great question.

THE COURT: Would that be her shift in language just because she chose to type in therapy as opposed to counselling?

A. The word "counselling" and "therapy", in our world, are interchangeable. So I'm not sure. But the fact, and, yes, in every note, there's a sense of the person's self in there. So I'm not sure whether or not Mary just used the word therapy and he used the word counselling. The bigger piece is that he moved from, they would have been his words, couple to individual. Those would have been the bigger keys. Not the counselling and therapy.

THE COURT: More important than ... Okay. Thank you. Sorry, Mr. Murray.

A. No, that's okay.

MR. MURRAY: If a caller is more distressed and if there appears to be immediate danger, for example, if something is really intense. Obviously, either admin or counsellors or therapists or social workers can access 911?

A. Yes.

Q. And would?

A. Yes, 100 percent.

Q. If there are safety concerns, if the person that's speaking to the client gets that sense, do you investigate for the risk of suicide and homicide?

A. Uh-huh. So with the nature of the work, understanding that we are meeting people on not their best days and we are leaning into the private complexities of their lives, we are constantly assessing for safety. So all of our bricks and mortar offices have safety buttons, panic buttons. They're little pendants and workers have them in the offices, admin have them, and they're linked directly to the police. If you press a button, you know, the police are at our office within a 10-minute timeframe or something like that. So the thing with the levers, the system itself, which is a beautiful thing about this system, too, is that it gives a consistent ability for our workers to reach resources when they need them. So the admin

wouldn't be accessing the extra resources, like the suicide or the homicide risk assessments, which I think I gave copies of to you.

Q. I'm going to look at them, yeah.

(12:40)

A. Yeah. But if the level of duress on the phone, if the individual was experiencing that level of duress, the admin would either pull one of us in, which I would think that they would do, or they're also fully aware that they can call 911 themselves and link that person in or child protection or whatever that risk was. If the individual had moved into, if I had to come on the phone or if they had gotten to, Mr. Desmond had received a first call intervention from our social worker and, in that therapeutic conversation, our social worker, who is constantly assessing safety, if they felt like there was things that the conversation was saying or the level of history or a plan, then they start to compile those forms that I use. They can pull up the system and they can engage in one of those two forms.

EXHIBIT P-000314 - SUICIDE AND HOMICIDE FORMS

Q. So perhaps we can bring those up, Exhibit 314. So there are two forms together, I think, that are marked as

Exhibit 314 and the top one says, Suicide Risk Assessment Revised.

A. Yeah.

Q. Is this or was this at the time a document that your therapists or counsellors would use if they felt there was a suicide risk?

A. Yeah, they're embedded in the system. So one of the things about the system was, it was a collaboration of Family Service Atlantic. We pooled our resources to ... There was five Family Service organizations involved a number of years ago, probably 10 years ago. We pooled our resources to try to find the best data management system that was going to meet our needs. Not all data management systems are created equally and we, up until that point in time as an organization, did not even have one. And so when we collectively pooled our resources and we came across this software, then we collectively did orientation and training and we collectively put our resources into it, such as the suicide and homicide. So these particular forms are, their history is out of Family Service Atlantic and they're kind of a culmination of multiple other evidence-based forms. But the reason that they were included in our data management system is it's the nature of the work.

Family systems work is difficult work and most of our clients are not going to be involved in suicide or homicidal thoughts but people ebb and flow into different emotional states relatively quickly and our workers need to have as much access to resources as they possibly can to help mitigate those risks and those situations. And so when the data management system came out, that was one of the great things about it is everybody could finally have the same, access to the same resources.

Q. So this Suicide Risk Assessment tool, you said it was kind of put together based on other evidence-based risk assessment tools that you had put together or were aware of?

A. Yes, because I just had, in preparation for today, I asked our therapeutic supervisor, I said it's timely that we look at these forms. I'm curious, I want to do a deeper dive into these forms. And what we came out with was that they are a typical family service version. They are conversational based. So they're forms that are, the ebb and flow of them are, they're natural enough that we can ask the questions and move through them based on the natural flow of a therapeutic conversation. And the second piece that she brought to my attention was that they are very engaging. They're scaled and so, if you move the form up and down, they're based on a scale of their level of

intensity. So they give the ability of the client and the worker to scale how they're feeling. And so all she was saying was, because they predate us, we didn't implement them. They came prior to us but they are a combination of most of the evidence-based suicide and homicide forms that are out there.

Based on our prep for this Inquiry, there is some things in here we're going to change. For example, we do a lot more assessing of safety and a lot that's a language change for us about these forms and less about risk, more about safety. It's kind of where we're at.

Q. So there are different categories on Suicide Risk Assessment.

A. Yes.

Q. I assume from what you've said that this is not a situation where, you said it's conversational, it's not a person asking questions and filling out forms.

A. No, it can't be that, exactly.

Q. You gather the information organically in conversation and cover the areas.

A. Exactly, yeah.

Q. All right. And on your Suicide Risk Assessment, the categories or, I guess, the particular points that the person

who is having a conversation with will want to talk to the person about is whether they have a plan, recent difficult events, history of suicidal attempts or self-injury, deterrents to suicide, safety plan, a level of intensity. Would the person simply be asked or is that something that the therapist might judge just from the answers to the other questions?

A. Yes, I would say either could occur but my thought would be it would be more the therapist interpreting that, yes.

Q. And then they are asked to assess risk, this is on the second page, low, medium, high, reason for risk rating, action taken, additional action planned. That's more, I guess, the go-forward what you're going to do, if you feel that the risk is there or it's higher.

A. Yeah. The thing with, because of our tiered service, is that it would be rare for us to be in contact with a person that was actively involved in a suicide plan or an action. But that not being said is we're fully aware of the importance of our conversations that we're having with people, which is why the forms are in there. You're having intimate private conversations and you're constantly gathering information. So is the person talking about a plan. And it's one thing to have a plan, is there another part to having the actual means to

carry out that plan and is the plan something that seems very based in reality and is there dates and times associated with it. So you're constantly just collecting information. And, at the end of the day, our workers, we don't, we're not the workers that are going to make the diagnosis. We're not the workers that are going to make the charge or hospitalize but we are all about consultation. So as soon as these forms are engaged, then we're also engaging, we're asking these workers to engage in a consult with their supervisor to kind of unpack what's happened and make sure that we are on the same page with the actions taken forward. Ultimately, we as a system, especially a Tier 3 system, we need to lean into the Tier 4 and Tier 5 systems. We need to lean into the emergency room and the structured mental health because, as soon as we have somebody who we feel is high risk for suicide, that's where we're sending them. That's where we're either driving them or transporting them to receive the hospitalization. We are fully aware of where our scope of practice ends and so we are constantly saying to workers, Engage in these conversations ... in a conversation. You don't have to be right or wrong. You just need to have enough information and see enough risks and too few of safety elements that you're going to then enter into a consult. I say consult ... phone and

consult with Child Protection. You don't need to be the right or wrong. You don't need to know. You're not the child protection worker. You don't need to make that call but you can call and ask for a consult. This is the situation I have, this is what this person is telling me, and I need to know what you would recommend moving forward. I'm all about the consult with the specialty systems.

Q. So, first of all, if a worker gets to a point where they're accessing this form and using it and thinking about those factors, they're going to consult with a supervisor?

A. Yeah, we say, we highly recommend you consult with a supervisor. We have the same forms in place for the Help Line. We have part of what the implementation of the Help Line came with, I was hard on this one, with the funding, I said if we're going to do, launch a Help Line, we're also launching a 24-hour access to supervisors. So at the exact same time we launched the front-line work, we launched a supervisory 24-hour support system. It's really common. You get a hard call at 2 o'clock in the morning and that worker is not sure about whether they've done the call right or whether they're working in the right way and they have the ability to contact and consult with one of us supervisors, it is transformative to the work. You're not alone

and you shouldn't be alone doing this work.

Q. If the risk appears real, you say that your organization will lean into the Tier 4/Tier 5.

A. Hundred percent.

Q. And just so I know, early on you had referred to Tier 5, for example, as high risk.

A. Yeah.

Q. In the mental health world, we're talking about.

A. Yeah.

Q. What would be a Tier 4 mental health service be, for example?

A. I knew you were going to ask me that question. Mental Health would be better to ask. I think Tier 4 is more like the specialized therapy. The individual therapy. I'm assuming emergency room, like crisis, if we were to transport somebody, that would be a Tier 5. I get confused a little bit about where things fit within their system but, yeah.

Q. Okay, all right. But more intensive mental health treatment than you're able to give.

A. Exactly, same as police. If we're talking, if we're using the Homicide Risk, I mean we're not calling Mental Health. We're calling 911, we're calling the police. When we're talking

about the increased homicide. And we have all those beautiful, what came out of that Maxwell-George Inquiry, we came up with all those beautiful formats and pathways of communication around domestic violence. So we have the high-risk protocols and we have those working groups. So that came out of that Inquiry around how do we mobilize when we're at risk when we, as a community, feel like something is not okay.

Q. And then your Homicide Physical Risk Assessment form, so it's not just homicide, it's physical risks. So this would be if a worker is concerned that a person may perpetrate some active physical harm to their partner or to anybody, basically.

A. Yes.

(12:50)

Q. And it seems to take the same kind of general approach.

A. It does.

Q. Conversational.

A. It does.

Q. And that's, based on the evidence, that is the best way to assess both suicide and homicide risk.

A. For our tier of service, yes. It might, I would think that it might look different if you were a more specialized

service. I'm sure the police when they're assessing, they might use a slightly different, they have a different perspective and a different intervention point than we do but if you think about our service, we are still very much embedded in the strength-based client oriented Tier 3 service. So we want to continue to assess for safety and we want to make it consultative and we at the end of the day, our system is not the decision-makers. We don't decide whether somebody gets hospitalized. We don't decide whether somebody is arrested. So the forms are the way that they are on purpose so they allow us and encourage us to lean into those other systems that we need.

Q. Just circling back to 313, our Intake Summary, page two. None of the, for example, forms that we just referred to, Suicide or Homicide Risk Assessment, were engaged on January 3rd.

A. Oh, no.

Q. In that conversation with Lionel Desmond.

A. Not at all.

Q. And none were needed to be in that conversation.

A. Not even a thought, no.

Q. So that conversation which was in the vicinity of about seven minutes on January 3rd, the appointment is still set

for January 16th.

A. Yeah.

Q. And the only change is ...

A. Individual.

Q. Individual, okay. The next entry, sadly of course, is January 4th, "Client reported by media to be deceased, intake it, appointment removed."

A. Yes.

Q. So I take it your organization heard about the tragedy the next day.

A. We did, yeah.

Q. And would it take a moment to associate the news with the person who had called the day before?

A. Right. It was pretty immediate, yes.

Q. I know this is the question we ask and it's hard thing for witnesses and a little unfair but how did you feel when you learned that this had happened and that, you know, you had been speaking with this gentleman the day before?

A. We felt devastated, I think, and shocked. And I think for Mary and I, in particular, it created a real need to unpack and to discuss because we spent so long, particularly the building of services for men and boys, and the fact that he had

called on January 3rd and it was a Men's Health Centre day, and the fact that we didn't ... there was nothing in that call to make us think that we needed to do anything different. We just spent a long time trying to figure out, okay, could we have done something different. And what we took away from that is that we just need to keep transforming the services that we're offering for men and boys because back then, this was 2017, we didn't have the Help Line. We weren't even talking about those types of robust partnerships between government. We were still just little old Men's Health Centre, no funding, no just ... And so she and I just got kind of re-energized into the conversation of we can't take our foot off the pedal of this and we need to keep driving this home.

Q. It's natural, of course, to question and to look back and say, Did we miss something, was there anything in retrospect, hindsight being 20/20, were there any red flags, was there anything, I think you used the phrase, was there a bread crumb trail or was there anything, looking back on it, that you personally, or Mary, or the organization, see as something that you might have missed or something that could have been a red flag?

A. Not back in 2017. I guess what I would say now, if

these were the dates now and it was 2021, I'm reassured to believe that we have transformed the system to improve to step into yet another gap. So had Mary had that call on January 3rd with Mr. Desmond, she could have also added, And by the way, while you're waiting for your intake, we have this Men's Help Line and you can call it 24 hours a day and you can call it as often as you want and that's what I would like to see now when I look at that record, is there would have something else to offer that we could have done.

Q. And when ... let's assume for a second that that kind of a narrative happens today with a client, they call, and they're waiting for an appointment and they call for whatever reason, will they be told about the Men's Help Line?

A. Yes.

Q. Okay.

A. Yes, yes, yes. Now we have it, yes. And the same as the Women's Help Line and the All Genders Help Line, like now we are, at least we are beginning to be able to step even further into the gaps that we always knew existed, yes, they are told that.

Q. Are they given a lot of information about it, do you know how much typically? You know, if I call and I say, Look

I'm coming in January 16th, it's December 9th or something, I have to wait a little while for the appointment, how much information typically is given to me about what I can get from the Men's Help Line?

A. I would like to think that our admin are reflective of the need for that conversation. So some of the guys that are calling will pick that up and they won't need further explanation. They'll just pick it up and they'll go. I'd like to think that our admin are reflective enough and flexible enough to really delve into more of an explanation of the conversation when they can hear that that's what the person actually needs or if that's asked. We are very much aware that we are trying to not make our system. Our system needs to be structured and it needs to be licensed and assured and all those things. But a tight system often fails as people that it's trying to serve and so we're trying to make sure that our system stays flexible enough that, for example, if a conversation with an admin takes two minutes, that that's not less important than a conversation with an admin that might take 45, that might actually need to break down what the Men's Help Line is and the history of it. People might be interested in that. so we encourage the admin to give themselves enough time and to be

flexible and to be grounded enough to allow the conversations to meet the needs of the people that are calling.

Q. The last entry is from January 9th, service reviewed. I don't know what service reviewed consisted of or is that ...

A. So as soon as an intake, as soon as a file is removed, like an intake appointment is removed, that's our therapeutic supervisor, Bridget Revell, those are her initials, and then she sends a workflow, it's called, it's all internal to the system, to the intake worker, Ann Delynn, which is the ADM, on January 9th, to remove that appointment from her schedule. And so that's an admin thing meaning that we're kind of closing that case down. Just because a case gets closed in Penelope it's not to the general public or somebody trying to access care, it in no way gets rid of their ability to call it and re-seek that appointment again. You know, just because it closes administratively, it's just a matter of trying to keep our stuff as organized as possible.

Q. If a person makes an appointment and calls back and says I don't think I want it, thanks very much, anyway.

A. Yes.

Q. And then calls back, say, a month later, says, No, I do want the appointment.

A. That happens all the time.

Q. Will the running file pick up, yeah, I suppose it does.

A. All the time.

Q. Will the running file pick up with that same person?

A. Yes.

Q. They have a number associated with them or a case number.

A. Yes.

Q. You had said that you were modifying the Suicide and Homicide Risk Assessment slightly.

A. Yeah.

Q. I assume things like that are modified on a regular basis.

A. Well, this prep for this Inquiry made me go back and look at those and realize that, yeah, it's time for us to update the language around safety instead of risk and just to do a deeper dive into them. Make sure that we are all comfortable with what the flow of them and what we're actually seeking the information on all those things.

Q. Now I would normally ask what else has changed as a result of this but, obviously, there are other things that have

changed significantly.

A. Absolutely.

Q. In the meantime.

A. Absolutely.

Q. Particularly Men's Health.

A. Hundred percent.

Q. Are there other changes from 2017.

A. '17, yeah.

Q. 2017 that ...

A. The overall momentum in the province and the recognition that men and boys and people who identify as being male need support and that support for men and boys and people who identify as being male is really about providing safety for women and children and a collective safety for all citizens. It's not about taking something away from another group. It's about adding something important to. Another huge change is an awareness that if put dollars into the prevention and kind of earlier intervention in the lower tiers of service, then we can keep the specialized services open and available for the people that we need to access those in a timely fashion.

I'd like to say that we've moved really into beautiful collaborative relationships with most of the government

departments in terms of them leaning into community to actually deliver the programming and that will only benefit clients.

It's interesting that Mr. Desmond contacted our organization. Our organization, as much as we are a community-based not-for-profit with limited funding, we are often at the end ... we are often the phone call that people make that are in great duress in our communities and that's because people live in communities. And so if we're going to provide care and safety, we need to pay attention to what the community can offer. You can't only fund the government departments because people don't access the government departments in the same way that they lean into community. Not much happens in any of our communities that we provide service in without some sort of touchpoint with us.

Q. I think those are all the questions I have.

A. Thanks, Allen.

MR. MURRAY: Thank you.

THE COURT: Thank you, Mr. Murray.

THE COURT: Ms. Ward? Ms. Grant?

MS. WARD: Ms. Grant has some questions.

(13:00)

THE COURT: All right. We would ... we normally would

be breaking for lunch at this point but I think I'm just going to kind of continue if everyone is content to continue. Are you all right to continue, Ms. MacDonald?

MS. MACDONALD Absolutely.

THE COURT: Thank you. All right. Thank you. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. GRANT

MS. GRANT: Hi, Ms. MacDonald.

A. Hi.

Q. My name is Melissa Grant and I'm representing, along with my colleague Lori Ward, the various federal entities ...

A. Oh, okay. Okay. Great.

Q. Including Veterans Affairs, Canadian Armed Forces.

A. Okay. Sure.

Q. One question about something you said earlier about the tier system. And I won't quiz you on exactly what is included in each tier.

A. Great, I appreciate that.

Q. But your point earlier about saying that there's this

potential thinking that the top tier was better, can you just expand on that a little bit?

A. Uh-huh.

THE COURT: Are we talking about the mental health tier or are we talking about Department of Community Services tier?

MS. GRANT: Mental Health Care.

THE COURT: Thank you.

A. Yeah. I think the mere nature of our healthcare system is invited to present the specialists and the people with the most academic training as the most knowledgeable and you see that in the implementation of the trauma language. And we didn't really speak much about the trauma language. The trauma language ... and I'll ... it's relevant, which is why I'm talking about it right now.

The trauma language has been, in my career of 24 years, it has been the most mobilizing and cohesive language that our province has ever seen. And that has occurred in the past eight years. It was the first time I saw a language used that was used across government vertically down within government and across community. And it was like for the first time we were all going to speak about trauma and actually the care for citizens using common language. It's been beautiful.

The Public Health Agency of Canada contracted my coworker Art from Family Service of Western and I to do trauma and violence informed training across Atlantic Canada. So I have this immense passion for this work and how it can be utilized in systems to provide better care for the citizens that we are hired to provide care for.

Health has been invited to take on the idea of trauma as from a specialist down in terms of a diagnosing of trauma and invited to use the trauma language as embedded in the individual. Community and the Public Health Agency of Canada, we have invited people to completely flip it and use trauma as the knowledge is embedded actually in the individual, that the individual has immense knowledge about what they need, what they need in terms of housing, food, you know, relationships, all those things. And that so we embed the knowledge in the individual and we use the systems and the specializations based on the process that the individual is seeking. So we completely have flipped it.

We also flip trauma in the sense of knowing that trauma is a process of becoming overwhelmed. We invite a possibility of looking at trauma responses instead of using trauma as a diagnosis. And, more importantly, we pay a lot of attention out

of the research ... the Canadian research around trauma is exclusively done with women and we're trying to open up conversations about research around trauma and trauma responses specifically to men and people who identify as being men.

We've utilized the Canadian Research of Trauma, particularly Nancy Poole, and the nursing staff out of the University of Victoria. We use their language. But it is based in knowledge with women. But we're just using it for men because we don't have anything else right now.

But the point of that is that they talk about trauma being experienced at an intralevel, which is within the individual, as an interpersonal level, so between ... relationships between coworkers, between community, and then at a systems level. When you pay attention to trauma as potentially occurring at all those levels, you realize the importance of paying attention to the care that is happening with an individual outside of just themselves.

Mental health is an experienced ... we need to get to a place where we are accepting the fact that mental health is not occurring within the individual. Mental Health is occurring out here of the individual. And if we truly want to create safety and elements of change, then we need to pay attention to the

"out here". We need to pay attention to the inter and we need to pay attention to the systems.

MS. GRANT: Thank you. Thank you for that explanation. Again not to quiz you ...

A. That's okay.

Q. ... but earlier you mentioned 12 determinants of health and ...

A. I did.

Q. ... noted they were quite Canadian. So I guess I was curious about what's the Canadian element of that. And then the part two of that is whether peer support or friendship or close ...

A. Oh, yeah.

Q. ... social relationships are on that list.

A. Yes. Yes. And I was really hoping that nobody was going to ask me to repeat the 12 because you can google the 12 which I would recommend. What's Canadian about them is they were developed by Canadians ...

Q. Okay.

A. ... by Public Health Agency of Canada. What's interesting is that the world is using them as a very interesting philosophy and perspective about how to view health.

We need to view health as holistic. We need to view health as being ... mental health, in particular, as being intimately connected to housing, job security, culture, race, relationships. If you don't pay attention to a person's mental health in the context of those social determinants of health, then you are embedding the issue within the individual and that person has no platform to stand on for hope.

Q. Do you find that ... in your work, that ... because you've interacted with probably thousands of men.

A. I have.

Q. Is there maybe an issue that you're trying to address where ... I'm not being very articulate about this.

A. That's okay.

Q. As like ...

A. Go ahead.

Q. I'll use myself as an example.

A. Go ahead.

Q. You know, I have a ... you know, what I would call like a robust sort of group of female friends that are sort of a godsend in terms of, you know, getting through daily life. And it seems like men don't necessarily have that as much as women do and I'm just wondering if that's something you came across

... you've come across in your work.

A. Every day. Every day, the isolation that is articulated and witnessed is pretty profound. And when you talk about the social determinants of health, that whole relationship piece is in there. When you look at the tiers of DCS and the Strengthening Fathers program that's trying to be rolled out, it pays immense attention to the need to be in relationship. Not for us to define what that relationship is. We all want safe relationships.

But the fact that people ... human beings, men included, and people who identify as being male, there is an immense need for relationship. And you asked me a question the other day about drop-ins or peer supports. One of the most fascinating takeaways after those 20 years of facilitating respectful relationships was this comradery that would occur within the group.

At first, nobody wanted to be there at all. Session one, nobody wanted to be there. Session two, they're starting to warm up and they're starting to realize that George Rodgers and I ... he's my old facilitator. He's a retired probation officer ... that we weren't that bad and that, you know, we were going to have food and feed people. And so we were going to make it

kind of pleasurable even though the topics were heavy.

But there would be this comradery just start to establish. And I realized what was underlying was how incredibly isolated these individuals were and that coming together and beginning to unpack what was a lot of shared grief, shared hurt, shared trauma, shared childhood stuff, not that that wasn't the group ... that wasn't what was in the program manual. That's just what was coming up was that there was this comradery.

And I can't think of a single group that we ever ran where the questions were, Can we continue to meet? And I would say, No, we can't continue to meet because you can't ... I'm not going to continue to give you psycho-educational programming if that's not what you need. But you can meet informally. Can you continue to meet outside of this? Do whatever.

When I think of the ... I'll loop it back to the library or the Family Place Resource Centres or the ... how important it is for men to see themselves as integrated into communities. The more a person feels on the fray of something, the more a person feels pushed out of relationship, whatever they define that is, the more at risk they're going to be to self-harm and to harm others.

So it's like all ... that's what DCS is trying to do with

those Tier 1 and Tier 2. Where are those drop-ins? That's what part of our SHIFT grant was from the Status of Women was to create a men's drop-in, was to create the Boys' Shed for the programming. It's about informal supports. If we put money into informal supports, how much of an impact can we make in terms of keeping people far away from the highly specialized services?

Q. Thanks for that answer as well. Those are my questions. I just want to thank you. Your passion for the work that you do is very evident to everyone and it's important work, so thanks.

A. Well, thank you.

THE COURT: Mr. Anderson?

MR. ANDERSON: No, I have no questions. Thank you.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD Mr. Morehouse has some questions, Your Honour.

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

CROSS-EXAMINATION BY MR. MOREHOUSE

(13:10)

MR. MOREHOUSE: Good afternoon, Ms. MacDonald. My name is

Tom Morehouse. With my co-counsel, Tom Macdonald, we are counsel to Ricky, Thelma, and Sheldon Borden or the father, mother, and brother of Shanna, and the grandfather, grandmother, and uncle of Aaliyah Desmond.

A. Okay.

Q. I've just got one question for you. In the work that you do, the men's health umbrella, are there unique programs, services, or approaches directed towards the African Nova Scotian community, in particular, and, if so, what are they?

A. Yes. And kudos to the Status of Women and the Standing Together grant. There's been a lot of attention to funded projects and programs run by African Nova Scotian small community organizations and delivered in those communities.

For ourselves, as part of an organization, the Men's Health Centre in and of itself, we don't deliver anything specific that is specific to the African Nova Scotian population other than the Families Plus program and that's central based.

So it's one of those things that I can't wait to see what we can develop more of, paying attention to ... DCS uses the language that one of their guiding principles is understanding that we need to pay attention to racially-diverse programs and marginalized populations and honour the fact that there has been

systemic racism in this province. And so a hundred percent we are moving forward with trying to hear from community about what's needed and working with our government departments to mobilize whatever we need.

One thing I will say is the help line, we have tried to make a commitment to understanding that if you're going to deliver something important like the Men's Help Line and understanding how important race is to accessing service, that if someone identifies being African Nova Scotian and they're wanting an African Nova Scotian counsellors, that we will do everything we can to make that match.

Q. Okay.

A. Yeah.

Q. In your experience, have you identified specific unique needs of the African Nova Scotian community?

A. Oh, sorry. Special unique needs of the African Nova Scotian community. Well, one thing that I would say is that a unique need is they need to see themselves represented in the healthcare fabric, which we have made a dedicated attempt to do that within our organization. They need to see themselves represented.

And the reason I'm linking that to the Men's Health Centre

and the Men's Help Line is representation is key. If, early on, when we were thinking about the Men's Health Centre, all I could see in the papers and in the media about men and boys was when they got into trouble with Department of Justice and their names would be listed. So and so did this, and, This is another robbery, or, This is another ... and I kept thinking, Where are the hope-filled stories and the strength-building stories about dads or about brothers or about sons or about veterans or about whatever? Right? Where are those? No one is going to step up to accessing service if they are already deemed and already judged as being a something.

If you open a service that is accessible and you represent and you show, all we did was hang a sign on the main street in Antigonish that said "Men's Health Centre" and we put up flyers across the town. That's all we did to open the shop. And the response kept saying, It's the first time I've actually seen myself, as a male, being possibly represented in something that I could access.

So I like to think that the African Nova Scotian population is something that we need to do better, we need to be better represented in our healthcare system. You need to feel like you belong, that you have a say, that you have safety and control

over process. And part of that is seeing your value, seeing yourself as valued.

Q. Thank you. Those are my questions.

A. Okay.

THE COURT: I'm sorry. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(13:14)

MS. MILLER: Thank you, Ms. MacDonald. My name is Tara Miller. I'm counsel representing the late Brenda Desmond, Cpl. Desmond's mother.

A. Right.

Q. And I also share representation with respect to the late Aaliyah Desmond with my friends Mr. Macdonald and Mr. Morehouse.

A. Okay.

Q. My question is really just on one phrase that you used which I found interesting in your evidence and I wanted to ask you a little bit more about that. You used the phrase "severe system harm".

A. Uh-huh.

Q. You raised it in the context of the Men's Health Line

and I think the example you gave of that, someone is on call and the call dropped due to technology. Unfortunately, that ...

A. I did.

Q. ... can be interpreted in a very unintended way ...

A. Yes.

Q. ... way ...

A. Yeah.

Q. ... by the caller. Is "severe system harm" a clinical term?

A. No.

Q. Okay.

A. It's a trauma language.

Q. Trauma language.

A. Yes.

Q. Yes.

A. The community-based version of the trauma language talks about a recognition about system harm and that people live their lives, we all included, with bumping into systems. And depending on our experience with those systems and our experiences based in our culture and our race and our socioeconomic status and all those things, that very well-intentioned systems can be engaged in system harm.

Q. And what is the outcome ... I appreciate that's not a clinical term. It is a trauma language. But, you know, from your perspective working in the field, with the expertise that you've developed and the knowledge that you have, you teach trauma- ...

A. I do.

Q. ... informed approaches. What's the outcome of that severe system harm?

A. It's profound. What it does is it begins to become embedded in the individual that they are not heard, that they are not cared for, that they're not represented in society. What we need to move forward with is a recognition from all of our systems that at the very moment that we fall in love with our system is at the very moment that we potentially might be harming someone, that we need to continue to be reflective in every one of our systems. That, for example, with us, with me with those forms, as soon as I knew that I was coming, I looked at them and I thought, There is room. We need to move these forms forward to make sure that they are reflective of the work that we're actually doing.

It's about not falling in love with any of our systems. It's about constantly hearing from where our systems are not

doing such a great job, where our systems are failing the very people that we're supposed to be serving. There's not a single one of us in this room that is not here because we are supposed to be serving someone. And often, as systems, we lose sight of who is serving who and systems end up serving systems. And that's what I'm talking about with the system here.

Q. And the impact on the user of the system ...

A. Profound.

Q. ... can you elaborate on what that severe system harm is?

A. Right. Until the trauma language, we didn't have any way of recognizing that. And the trauma language gave us an opportunity to create open dialogue about system harm without system blaming. I think of a couple of systems within our province, three in particular that often were on the end of system blaming. And I think of mental health, I think of the police, and I think of child protection.

And the trauma language gives us ... it invites us to create space to actually engage in helpful dialogue with the systems. At the end of the day, we need those systems. And those systems are crucially important to the safety of the citizens of Nova Scotia. And system blaming is not going to

help us create better systems and it's not going to create less system harm. But open conversations about where systems can engage in transformation is what actually is necessary.

What systems ... what the impact for an individual ... when a system isn't reflective and doesn't acknowledge the potential harm, then the individual is left feeling that it's all inside them, which is not the case. People experience their worlds in those three ways, inside them, externally in terms of their relationships, and the systems. Most of our most high-risk individuals have immense experience with system harm, immense.

Q. Certainly, we've heard evidence throughout the Inquiry about the systems that Cpl. Desmond was involved in ...

A. Okay.

Q. ... including the ...

A. Okay.

Q. ... VAC system and just I was curious about from your experience and perspective what the impact is on those users of the system that most of your high-risk individuals have been ... spend a lot of time in those systems.

A. Yes.

Q. That is perhaps a determinant, if I can ...

A. Absolutely.

Q. ... in terms of their success in those systems.

A. A hundred percent.

Q. Is that fair to say?

A. Yes. The other thing I was going to add ... just made me think of what you were asking the question is that the tighter the system and the more siloed it is in making sure that it delivers with ... we all have a scope of practice and we all have a job to do, but the less willing we are to lean into other systems or lean into community, the more gaps we create. And the gaps are where the risks occur for our citizens of Nova Scotia.

The onus really should be that we all become, as workers, more intimately aware of the resources that our clients might actually need. The trauma language talks about having an equal amount of expectation of change for our clients as we do for ourselves as workers and of our systems. The trauma language is just such incredibly mobilizing language when it's used in the community format.

(13:20)

Q. Okay. Thank you very much, Ms. MacDonald.

A. Yeah. You're welcome.

Q. Your evidence has been very illuminating and ...

A. Oh, well thank you.

Q. ... comprehensive in your passion for the work. Thank you.

A. Thanks.

THE COURT: Mr. MacKenzie?

MR. MACKENZIE: Thank you. No questions, Your Honour.

THE COURT: Thank you. Anything further, Mr. Murray?

MR. MURRAY: I just have one question, Your Honour.

THE COURT: Very good.

MR. MURRAY: I had neglected to ask it.

RE-DIRECT EXAMINATION

(13:20)

MR. MURRAY: We've heard evidence from Cpl. Desmond's clinical care manager, Helen Boone. I believe she was previously affiliated with your organization.

A. She was. Yeah.

Q. She was employed by Family Services?

A. Yeah.

Q. Okay. Which may have been the genesis of the referral to Family Services.

A. I think so because she knew.

Q. Right.

A. Yeah. About us.

Q. So, again, it speaks to the ...

A. It does.

Q. ... necessity of knowing what services are available.

A. It does.

Q. Right.

A. Yeah.

Q. Thank you.

EXAMINATION BY THE COURT

(13:21)

THE COURT: Oh, I just have a question.

A. Okay.

Q. How do you get systems to talk to each other?

A. Oh!

Q. How do you get systems out of their silos? So in our situation here we have Cpl. Desmond who spent time in the Canadian Armed Forces and he was released from the Canadian Armed Forces, then he spent time in the hands of Occupational Stress Injury Clinic in Fredericton, then he was handed off to Occupational Stress Injury Clinic in Quebec. Veterans Affairs

had picked him up and was, by virtue of their mandate, assisting him on his journey through life, what was left. And we have when he was released from or discharged from the hospital in Quebec, the OSI Clinic in Quebec, he comes back here.

So they all had information. They all had invested time in him in as far as we can see and I may be overstating it a little bit, but they didn't have a lot of conversation with each other. And one of the things we look at is you look at all the siloed information ...

A. I know.

Q. ... that there was ... like all the siloed information may reveal. So how ... how do you have ... do you get those agencies to start sharing critical information or, first off, recognizing what's important ...

A. Well, that's ... yeah. That's ...

Q. ... and what should be shared and then ...

A. That's the first ...

Q. ... sharing it in a collaborative way so that at the end of the day when somebody like Cpl. Desmond comes in to the St. Martha's Hospital ...

A. I know. I know.

Q. ... on an emergency basis with his spouse, that

somehow the psychiatrist ...

A. I know.

Q. ... that he sees at the time has some reasonable opportunity ...

A. Yes.

Q. ... to make a judgement intervention.

A. Yes.

Q. How do you get the silos to talk to each other?

A. Well, this is the third Inquiry that I've been involved in since my time with Family Service. And I have had very positive experience with the recommendations that came out of the last two Inquiries that kind of propelled forward that need to talk to each other and I think specifically about the Nunn Commission.

So that created a round table of ... I don't think they're ... they're not at the ... well, maybe they're at the deputy minister level. I'm not sure ... or the person below that of the five core government departments, it was a recommendation that they form a working group and a conversation. So at least then you're saying it's not the expectation of just the front-line workers. It's the expectation of the five core government departments of this province. Start talking to one another

about client care. Right? So that was one of the things that happened.

And that round table, when it existed in its beautiful form, its purpose was that the Commission ... that Inquiry also recommended that we have community collaborative tables. And at that community collaborative tables, the government departments were to be represented and as was community, which there is still ... most of them still existing within the Province.

So you already have a bit of a framework moving forward in 2022 that has already been built in the last two Inquiries. Right? So it's not like it's not ... it's not unheard of. The difference in this one I think that you're saying, is we have a level involved in this case, from what I'm hearing you say, which is a federal level which is not part of any of the other things that we've been involved in.

Q. Correct.

A. Right. So ... but there has been movement in the past, based on the other two Inquiries about this propelling this forward. And great things have happened based on those other two Inquiries in terms of the breaking down the silos at the community level and at the government department level, based on the language of those recommendations. Yeah. No

pressure on you. No.

Q. No pressure. Thank you very much.

Ms. MacDonald, we certainly appreciate your time, as counsel have said. You provided us with some information. You give us some good insight. And, as I said yesterday, I mean this proceeding is live-streamed and the publicity that the help line gets ...

A. I know.

Q. ... and access to it by calling 2-1-1, I think it creates an opportunity ...

A. Yeah. It does.

Q. ... to get that message out. And whether as a result of today's evidence you have to hire more staff and try and find some increased funding, we would certainly support you in that regard.

A. Great. Yeah.

Q. So, again, thank you.

A. I'll be calling. Okay.

Q. We appreciate it. Thank you very much for your time.

A. You're very welcome.

Q. Thank you very much.

THE COURT: All right. Thank you, Counsel. I think

we're going to adjourn for the day. I'm going to ask counsel to remain for a few minutes to have a discussion about a couple of matters then. All right.

MS. MACDONALD: Okay.

THE COURT: So thank you very much.

MS. MACDONALD: All right. Thank you.

WITNESS WITHDREW (13:26 hrs.)

COURT CLOSED (13:26 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
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DARTMOUTH, NOVA SCOTIA
September 20, 2021