CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: March 11, 2021

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EXHIBIT LIST

March 11, 2021

COURT OPENED (09:30 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Murray? We have?

MR. MURRAY: Yes, Your Honour. First witness is Dr. Rudnick.

THE COURT: Good morning, Dr. Rudnick. How are you today? Can you hear?

THE CLERK: I think you have us on mute.

THE COURT: Oh. Can you take yourself off mute?

All right. Thank you. Good morning, Dr. Rudnick. How are you today?

DR. RUDNICK: Good morning. I'm fine. Thank you.

THE COURT: All right. Thank you.

Before we begin, we would normally swear a witness before we hear their testimony. You'll be given some options in a moment, Doctor.

DR. ABRAHAM (RAMI) RUDNICK, affirmed, testified:

THE COURT: Thank you. Mr. Murray?

MR. MURRAY: Thank you.

DIRECT EXAMINATION

MR. MURRAY: Good morning, Dr. Rudnick.

A. Good morning.

Q. Dr. Rudnick, as we go through the questions this morning if at any point you have difficulty hearing me, or if I have difficulty hearing you, we'll just let the other know and we can try to remedy the problem. Okay?

A. Yes, thank you.

Q. Dr. Rudnick, would you please tell the Inquiry your full name?

A. My name is Abraham Rudnick.

Q. And just so I'm ... I want to be correct. Your last name is pronounced ROOD-nik, is it?

A. Yes, correct.

Q. All right. Thank you, Dr. Rudnick. Doctor, you are the clinical director of the Nova Scotia Operational Stress Injury Clinic in Dartmouth, Nova Scotia. Is that correct?

A. Yes, correct.

Q. That's primarily, obviously, what I want to ask you about today, your work there, but we do have your *CV* as an exhibit and it's marked as Exhibit 259. Perhaps we'll just bring it up on the screen and you can identify it as your CV. It should come up in a moment there. I appreciate this is ...

EXHIBIT P-000259 - *CURRICULUM VITAE* OF DR. ABRAHAM RUDNICK

A. Correct. That is my *CV*.

Q. Very good, and this is dated March 1st, 2020. That's your most recent *CV*, is it, or ...

A. No, I have a more current *CV*. It's updated ongoing, but for relevant purposes for today there's no major change in my *CV*.

Q. Thank you. And, Dr. Rudnick, I'm just going to ask you a couple of questions about your very extensive experience and education. Your *CV* is lengthy and very impressive, but there are certain portions of it that are particularly relevant for us today. You are a certified psychiatrist are you, Dr. Rudnick?

A. Correct, I am.

Q. And I understand, if I'm reading correctly, that you have a Doctorate in Philosophy?

A. I do.

Q. Would it be fair, then, to also call you a bio-ethicist? Is that a fair term?

A. I have done teaching, research, and service development in ethics, and occasionally I have also consulted on ethics. Not as an appointed ethicist but as part of committee work.

Q. I see. And currently you ... apart from your work as the clinical director at the OSI clinic you're also a professor in the Department of Psychiatry at Dalhousie University? Is that correct?

A. Correct.

Q. And also I see you are cross-appointed as a professor in the School of Occupational Therapy, also at Dalhousie?

A. Yes, correct.

Q. And so, Doctor, you have a number of other appointments and a number of other positions that you currently hold or have recently held. Just to go back a bit. Your medical training originally you received in Israel. You received your medical degree there, did you?

A. Yes, I did.

Q. And your training as a psychiatrist also in Israel?

A. Correct. Tel Aviv Mental Health Centre and University of Tel Aviv.

Q. Very good. And you came to Canada in what year?

A. So first time was 1999 as a fellow at the University of Toronto for two years.

Q. Yes.

A. And then the second time to date was 2004.

Q. I see. And your current work as the clinical director at the OSI clinic, when did you begin that work?

A. October 2018.

Q. Okay. So it is that particular capacity that I ... that is of clinical director at the OSI clinic that I want to ask you a number of questions today.

At the outset, just to clarify, you personally, I understand, did not have any contact with or involvement in Lionel Desmond's file. Is that correct?

A. Correct.

Q. And you never met or treated Cpl. Desmond?

A. Correct.

Q. All right. So, Dr. Rudnick, you said that you have been the director at the OSI clinic since 2018. Are you able to tell us how long the OSI clinic in Nova Scotia has been open?

A. To my knowledge, our clinic has been opened since 2016 for clinical work. It was developed a bit before that, to my knowledge, from 2015 but open to the public to provide service since 2016.

Q. Okay. You personally have, obviously, some interest in the work that's done by the OSI clinic since you've come to work there. How did you come to have that interest or come to want to work at the OSI clinic?

A. So I can give a very brief introduction to my background with operational stress injury. So in Israel I practised for a few years as a military physician, general practitioner, before I started my specialty in psychiatry training. That was my introduction to work with people who have operational stress injuries in Israel. Then when I specialized in psychiatry in Tel Aviv the center I specialized in had a partial focus on operational stress injuries, specifically military veterans of the Israel Defense Forces. And so part of my training was with that population.

And then in the last few years since I've moved to Nova Scotia to work with Operational Stress Injury Clinic I've been focussing pretty much exclusively clinically on the population with operational stress injuries in Nova Scotia.

Q. I see. Okay. And perhaps you can help us a little bit by way of introduction, just first of all so that we have our terminology correct. The clinic in Nova Scotia is the Operational Stress Injury Clinic. Is that correct?

A. Correct.

Q. We have been using the terms "occupational stress injury" and "operational stress injury" throughout this Inquiry. Can you help us to differentiate those two terms?

A. Yes. First I need to remark that both are not formal diagnostic classifications, at least in psychiatry, but they are quite helpful and used often. And so an operational stress injury is a mental health challenge, to use a broad term, that's related to a person's military or police, specifically RCMP, service in Canada.

An occupational stress injury would be a broader set of categories that include other types of professions and their impact on the workers' mental health.

Q. Okay, so operational stress injury, then, is a subset of occupational stress injury, is that correct?

A. Correct. That's my understanding.

(09:40)

Q. Okay. To your knowledge, are there other OSI clinics?

We've heard, obviously, about the OSI clinic in New Brunswick. Are there other OSI clinics across Canada?

A. There are. In most provinces.

Q. Okay, and to your knowledge, and I appreciate you only work in Nova Scotia, but to your knowledge, do they do the same kind of work across Canada?

A. Yes, the operational stress injury clinics across Canada are mandated to do a particular type of work. There is variation - that is understandable - across the provinces in the way that these clinics operate and some of their additional foci in addition to the core mandate of Veterans Affairs Canada.

Q. Okay. The Operational Stress Injury Clinic in Nova Scotia. Can you, first of all, give us a general sense of the type of work that you do there and the type of patients that you see?

A. So the two main types of work we do at the Operational Stress Injury Clinic are assessments and interventions, and so assessments would, for example, include disability assessments, treatment assessments, both and some other types of assessments such as second opinions as requested by a referral source.

Interventions would include various types of psychotherapies, medication prescription, occupational therapy,

and that includes a variety of interventions with that and a few other types of interventions, both individual and group interventions.

Q. All right. And you said that the operational component, I guess, relates to military service or police service. Can you give us a sense of where your clients or patients come from and their makeup.

A. So our referral sources are Veterans Affairs Canada and RCMP Health Services. Occasionally we have direct referrals from other operational stress injury clinics in the country if a client is moving from one province or territory to Nova Scotia. But formally, that referral would still go through the formal referral source. So if the client is still an active RCMP member, then we would ask the local health services of RCMP to process that referral, and the same with the military veteran. We'd ask the Veterans Affairs Canada to process that referral.

And that's not just for processing. It's also to ensure that clients would not fall between the cracks, that they would have a local in Nova Scotia, a referral source that can also help them navigate the system.

Q. Okay. So I will ask you some questions about the referral process, but the people that you see primarily, then,

are veterans and RCMP officers? Do I understand that correctly?

A. Those are the two main populations. We have a small population of Canadian Armed Force members who are still serving who are planned to be released from the military, typically because of health reasons, and they may have just done an assessment - let's say at the military clinic - and with ... because they're expected to be released in a few months it does not make sense to only involve ... that they start their care at the military clinic and within a few months shift their care to our clinic and, therefore, even though they're still serving, we start to provide their services and connect with that military clinic.

Q. Okay. So some that are transitioning out of the Canadian Armed Forces but primarily veterans, and on the police side it's RCMP officers because they're Federal employees and you're funded by the RCMP in part, is that correct?

A. Correct, and they could be RCMP serving members or retired or released ... medically released and they ... I would think that perhaps the manager of the clinic, Patrick Daigle, who will be testifying later, could speak about the actual funding streams for that. But I could speak about that generally if need be.

Q. Okay. No, that's fair. So apart from RCMP members, though, you don't treat other municipal police officers, only RCMP, is that correct?

A. We do not.

Q. Okay. Apart from VAC, that is veterans, some Canadian Armed Forces members and RCMP members are there anyone else that might be referred to your clinic or is that basically it?

A. So we also treat, according to need and if approved by the referral source, family members, broadly defined, of clients of ours. But those family members have to already have a client who is being served at our clinic and then we, or sometimes private providers as referred by the referral source, could treat the family member if there is clarity that mental health care for the family member could improve the mental health of the client at the clinic.

Q. I see. So it has to be related to the mental health of your client treating the family member.

A. Correct.

Q. All right. The number of clients that you have, let's say, right now ... first of all I'll ask you. Is the Operational Stress Injury Clinic an inpatient facility at all?

A. No, it is not. All operational stress injury clinics

in Canada are outpatient/ambulatory services and not authorized to provide urgent care.

Q. Okay. So no inpatient beds, I guess we would say. How many outpatient clients would you have presently?

A. Approximately 200. The last count in the last quarter, so end of December 2020, was 206 active clients.

Q. Okay. And the Operational Stress Injury Clinic is located in Dartmouth, Nova Scotia. I'm correct on that, am I?

A. Correct. The main site is in Dartmouth. We have a satellite site in Cape Breton in Sydney, and especially in the last year or so with the current pandemic we've been doing a lot of remote care through online care. And so we provide service across the Nova Scotia province.

Q. Do you have a physical location, the sub-office that is, in Cape Breton?

A. Correct.

Q. Okay. Now you are the clinical director of the Operational Stress Injury Clinic. Can you give us a sense of what your duties are as the clinical director?

A. So as the clinical director I'm expected to run ... also provide clinical service, which I do, to ensure quality of care at the clinic and as part of that service development and

quality improvement and to facilitate academic work, which would be promoting evidence-based care for our clients. And so that is where my academic affiliation ties in as a professor who does teaching and research.

Q. So as part of your role as clinical director are you also expected to do research into evidence-based methods for treatment?

A. That is part of my contract.

Q. All right. Now you said that ... I think when we spoke earlier that the management of the OSI Clinic, it's a co-leadership model? Is that ... do I have that correct?

A. Correct. So I co-lead the clinic with Patrick Daigle, the manager, and recently since January 2021 we have a third person join our clinic leadership who is a clinical team leader, a social worker who provides half-time of her work, clinical services direct to clients and half-time as a clinical team leader.

Q. So there is you as clinical director, Mr. Daigle, who is going to testify, and he is the health services manager? Do I have that title correct?

A. Correct.

Q. Which would be more ... and obviously he will testify.

But more on the administrative side of things.

A. Yes.

Q. And then you said that the recently recruited clinical team leader, who is a social worker, who is that person who is filling that role right now?

A. Her name is Jessica Heidebrecht.

Q. Okay, and Ms. Heidebrecht, I'm sorry, what were her responsibilities as clinical team leader?

(09:50)

A. So half of her position is to continue to provide clinical service direct, specifically psychotherapies, and the other half is as a clinical team leader who is at the front line with the clinicians helping them problem solve, process clinical issues if they need that support, although both Patrick Daigle and myself are available to support that too. But she would be particularly available for that.

Q. Okay. Very good. So the ... I'm just going to ask you a few more detailed questions about operational stress injuries. We have a bundle of materials that were provided to us regarding the OSI Clinic which have been marked as Exhibit 261, and if we could bring that up and go to page 2 of that document. Sorry, let's try page 4.

EXHIBIT P-000261 - NOVA SCOTIA OSI CLINIC MATERIALS

Q. And you gave us the definition of an operational stress injury. And I believe it's included in these materials. It's a "term used to describe any persistent psychological difficulty resulting from operational or service-related duties", and listed in the document are some common operational stress injuries. Can you tell us about those, what the most common operational stress injuries are that you treat at the OSI clinic?

A. So the first preamble is that a client may, and often does, present with more than one mental health challenge. Sometimes it's one operational stress injury and other mental health challenges that are not an operational stress injury - may be related to their civilian life - and sometimes it's more than one operational stress injury clinic.

And so what we usually use is the terminology it's a primary disorder and comorbidities, other mental disorders and sometimes other physical health disorders that may complicate the mental health of the client. And so if we start with the first bullet there, post-traumatic stress disorder, PTSD, as a primary disorder, approximately that ... about 50 percent of our clients present with PTSD as a primary disorder and the rest

would have either mood disorders as a primary disorder or anxiety disorders such as panic disorder. For mood disorders, typically it would be either major depressive disorder or persistent depressive disorder.

Often our clients have comorbid substance use disorder, but typically we would not have clients who have only a substance use disorder as an operational stress injury and then there are other conditions. An example which is not unusual would be a dissociative disorder. Sometimes it is a secondary or comorbid disorder. Sometimes it's a set of symptoms related to PTSD, and sometimes occasionally, but not commonly, through the primary disorder.

Q. Okay. You say that ...

A. Very rarely ...

Q. Sorry, go ahead.

A. Rarely we have people with other comorbidities that are unusual for a client population, be it a psychotic disorder. It could even be a primary psychotic disorder. Very rarely it could be a dementing disorder such as Alzheimer or another type of dementia but that's quite rare for our clients.

Q. Okay. And just on that last point out of curiosity. The age range of your clients ... I hadn't asked, but do you

have a wide age range?

A. Age range is from their 20s to their 80s typically. Rarely 90s.

Q. Okay, so as a primary OSI you say post-traumatic stress disorder, or PTSD, is perhaps 50 percent ... in 50 percent of the cases that's the primary disorder, is that correct?

A. Correct.

Q. Is it more common that there are multiple diagnoses and comorbidities than when there is just one?

A. Yes, absolutely.

Q. Okay.

A. That is the common situation.

Q. All right. And is it possible that a patient may have multiple comorbidities going on?

A. So by definition, comorbidities mean one or more comorbidity, and yes, it is very common for people to have more than one comorbidity. Often both mental and physical comorbidities.

Q. Okay, so for example, a patient may present with PTSD and also major depressive disorder, for example, which would, I take it from what you said, fall within the mood disorder

category? Is that correct?

A. Yes, correct.

Q. All right. And you say that patients can also present with ... or it's not uncommon for them to present with physical conditions as well along with their mental health difficulties?

A. Commonly. There are at least two types of physical comorbidities, one that are at least partly service related. Sometimes disability awarded by Veterans Affairs Canada, such as head injuries that occurred during and in relation to military or RCMP service and then another type are physical health challenges that are not related to the service but over time accumulate and is expected the older the client, the more likely are those types of physical comorbidities.

Q. So if a patient has a physical comorbidity ... that it would have to be related to their service, obviously, would it, for treatment? Or not?

A. So obviously, all clients are deserving of any relevant healthcare, including for non-service related issues. The question is more about what do we, as an operational stress injury clinic, do to provide care? And so there may be time later. But I can just briefly mention that we do have primary care providers at the clinic and they would address with their

clients all physical health challenges not just those that are service related and disability awarded.

Q. Okay. So if a patient presented, for example, with a chronic pain condition that would be something that you might treat at the clinic?

A. We do treat that in a variety of modalities.

Q. All right, and if a person ... you referenced a moment ago if a person had a head injury and as a result had, maybe, a neurocognitive impairment. Are you able to provide treatment for that at the OSI clinic?

A. Yes, we are. So especially our occupational therapist providing what is called cognitive remediation, which I think is a very, very important part that I would like to highlight. Because it's not commonly practised in general in Canada, you know, just for people with operational stress injuries. And it's very important to address that.

It's not only for people with head injuries. People with persistent complex or severe mental health challenges often do have neurocognitive impairments such as attention problems, memory problems, problem-solving problems, et cetera, and sometimes the psychotherapies and the medications are not enough to address that and that is where cognitive remediation comes

in.

So we're currently actually working with developing a full program for that, but even before that we are providing that. And as needed, we do assessments for that, either occupational therapy assessments or psychology assessments, and when we need a complex full battery of neuropsychological assessment we refer out. Typically, we would ask the referring source, such as Veterans Affairs Canada, to find a community-based neuropsychologist and to have that assessment done and we've had success with that. So we work collaboratively in that sense with some community providers.

Q. Okay, so that's interesting and important that we talk about the cognitive remediation, but let's just back up a second and speak more generally about the types of treatments that you provide at the clinic. So we've talked about a number of the conditions that ... and comorbid conditions that we often see. What is the treatment approach and what treatments are available at the OSI Clinic?

(10:00)

A. So I'd like to frame it in a general way and then I'll go into some specifics. So in mental healthcare in general ... and that's published about this. There are at least four main

types of interventions. One is medications. a second is psychotherapy so of a variety of sorts. The third is what's called neuromodulation, which is a physical electric magnetic treatment such as electric convulsive therapy, trans-cranial magnetic therapy and so on. And the fourth is psychiatric psychosocial rehabilitation where cognitive remediation sits. So all those four types are either provided by the clinic or sometimes outsourced for.

I'll start with the medications. There's a variety of psychotropic medications as we call them: antidepressants, anti-anxiety medication, sleeping users, antipsychotics, and others and we prescribe them or, occasionally, if the client prefers that we recommend to a community primary care provider to prescribe that with our guidance.

The psychotherapies consist of a variety, some more/some less-evidence based and they're focussed specifically on types of conditions. So, for example, for PTSD there are three most evidence-based psychotherapies and that would be prolonged exposure therapy, cognitive processing therapy and eye movement desensitization and reprocessing, EMDR. Those are, for lack of a better word, sanctioned by Veterans Affairs Canada but sometimes other psychotherapies are helpful too. For example,

for depression of particular types there's a psychotherapy called interpersonal therapy, which we've trained some of our clinicians on, and that could be as helpful.

We also use the more generic cognitive behaviour therapy, sometimes acceptance and commitment therapy, depending on the particular issue and we also use group modalities. So therapies, for example, we have dialectical behaviour therapy, group skills training modality. We have a family and client educational group.

We're doing a pain group, pain management group, for the clients. Some are evidence-based, some are evidence informed. If there's interest, I can try to help understand the difference between evidence-based and evidence-informed and emerging, those are three categories of health interventions.

And then I mentioned the neuromodulation or stimulation. For our clients, occasionally we do refer them out to TMS, transcranial magnetic stimulation. We don't have that at the clinic. There is at least one (inaudible - audio) for that in Nova Scotia, hopefully soon more. It's typically evidence-based for depression that either doesn't respond well to other modalities like medications and psychotherapy or perhaps the client is not interested in medications and maybe psychotherapy

isn't working well enough and then we can add on TMS.

And the fourth type that I mentioned is PSR, psychiatric psychosocial rehabilitation which includes, as I mentioned, cognitive remediation but also includes other modalities that are specific to practical skills training and generating and maintaining supports that help people in their, what's called environments of choice. Sorry for the technical jargon. PSR is part of my expertise. If this is too technical, please let me know.

Q. No, that's fine. We'll just go through these kind of ... and bear with us because we're not medical experts, but I'll ask you a few questions about the four general categories of treatment that are available.

So obviously the first you said was medication, psychotropic drugs, which you are able to prescribe. I haven't asked you yet about the makeup of the clinic, I'll do that in a moment. But you have psychiatrists on staff apart from yourself that are able to prescribe medication, is that correct?

A. That's correct. We also have a family physician and a nurse practitioner who can also prescribe, including psychotropics.

Q. All right. And then the second would be the

therapeutic evidence-based and perhaps not evidence-based therapeutic treatments that I take it would normally be given to clients by psychologists. And you talked about the three most evidence-based, I guess, and sanctioned forms of treatment for post-traumatic stress disorder. Do I understand that correctly?

A. Yes, with just a slight correction. It's not just psychologists who do psychotherapy and are authorized to do that. A variety of other professions do that, social workers, nurses if they are trained, psychiatrists can do that, occasionally occupational therapists for specific types of psychotherapies.

Q. Okay, understood. And we've heard from other witnesses previously about the three most widely accepted, I guess, and evidence-based treatments for PTSD, the prolonged exposure, the cognitive processing therapy, and the eye movement desensitization. Can you give us just a ... I appreciate this may not be your specific area but can you give us just a sense of what those three treatments are?

A. So all of these treatments are based on a principle to some extent of exposure. So that the more the client processes the troubling memories of whatever incidents they have been involved with, witnessed, experienced and so on the more they

habituate and the less stressful those memories become. But each modality, each intervention does it somewhat different the focus could be a bit different. Prolonged exposure therapy is still the gold standard for that exposure experience.

Cognitive processing therapy focuses more on the thoughts related to those troubling memories and can be particularly helpful for experiences such as moral injury which often come with PTSD. If need be, we can talk a bit more about moral injury.

And EMDR has evidence to show that it can help people who are not as comfortable articulating with a clinician those troubling memories. Because that by itself, just talking about those traumatic experiences could be triggering, which could be processed in therapy but some people can't tolerate that and, therefore, doing it through EMDR is sometimes more helpful.

Now in addition to that sometimes clients come with what's called complex PTSD. So often complex PTSD is an OSI complicated by other traumatic experiences, typically developmental mental trauma, so trauma in childhood, be it physical, sexual, verbal, emotional or other abuse or severe neglect, and when that occurs, we try one evidence-based psychotherapy for PTSD.

The experience, and that's more anecdotal, is that sometimes EMDR may be more helpful for that but it is anecdotal. Head-to-head comparisons, meaning comparing one of those evidence-based trauma-focussed therapies to another in a rigorous way with large samples of research participants have not been really done much unfortunately.

And so it's very difficult to this day to do treatment matching to decide in advance which of these three trauma-focussed therapies is a better fit for this particular client, of course, beyond their personal choice, which is imperative.

Q. So you offer at the OSI clinic each of those three treatment modalities, the prolonged exposure which you say is the gold standard, the CPT, and the EMDR, correct?

A. Correct.

Q. And I've understood from other witnesses, the prolonged exposure and cognitive processing therapy requires, for example, or it can, clients writing down or keeping a diary or recording their thoughts, and can also involve what I understand is imaginal exposure versus *in vivo* exposure, do I have that correct?

A. Yes, absolutely, the different types of exposure. Ideally, we would get the client to the point where there's *in*

vivo, meaning in real life exposure. An example would be if they're very suspicious, hypervigilant, easily triggered in crowds, eventually we would hope that they get to the point where they're doing the exposure in crowds, pandemic aside obviously, but as much as possible behaviorally exposing themself because that would be the most effective way of trying to address the trauma.

(10:10)

Q. All right. Apart from those three treatments you said there are other in this category ... I guess in the second category, there are other treatments that are perhaps less evidence-based but the OSI clinic is trying them. Do I have that correct?

A. Partly. So maybe I'll explain. Interpersonal therapy, IPT, is a highly evidence-based psychotherapy for depression with specific indications within depression. For example, for transitions in life. Someone is transitioning from the military and has become depressed from that, often IPT could be a good solution for that. There are other indications within depression for that, so that's evidence-based.

There are other types that are evidence-based. Motivational interviewing, which is somewhat of a psychotherapy.

It's really a way of connecting with a client and it's very evidence-based for substance use challenges but also for more and more evidence-based for appearance challenges. If a client is not taking their medications regularly - be it for mental health purposes or even for high blood pressure or diabetes - motivational intervening can help with that to some extent.

Our client and family education educational group is an emerging modality that we're doing research on, so that would not be evidence-based but it's evidence informed.

Q. I see, okay. And those are all forms of treatment and intervention that you offer now at the OSI clinic, are they?

A. Correct.

Q. All right. You also made reference to a category "neuromodulation", do I have that correct?

A. Correct.

Q. And be patient with us. Can you give us a basic understanding of what neuromodulation is?

A. So neuromodulation is a set of biophysical interventions typically using either electric stimulation or magnetic stimulation in order to improve various mental and neurological conditions.

It ranges from one of the easiest to implement clinically

such as TMS, transcranial magnetic stimulation which I mentioned, which is fairly benign, nearly no adverse effects from that, up to electroconvulsive therapy, ECT, that has been practiced for many, many decades, it's highly evidenced for severe depression such as psychotic depression, to the most extreme form which is DBS, deep brain stimulation, which is done sometimes for Parkinson's disease, sometimes now also for severe depression, sometimes for obsessive compulsive disorder, where an electrode is inserted into the brain by a neurosurgeon, placed there, and could be stimulated on and off in order to try to regulate those areas of the brain that are deemed to be responsible for that mental or neurological condition.

Q. And are those interventions available at the OSI clinic or do they require cooperation with a community health provider as well?

A. So none of them are available at our clinic. We do outsource them. But from my experience to date at the clinic, the only intervention with neuromodulation intervention we outsourced has been TMS which, as I said, is one of the most benign, the easiest clinically, but not easy logistically because it has to be done every day for five days a week for at least a few weeks and it's currently only available in Halifax.

Q. I see. All right. And finally, the fourth general category of treatment or interventions that you provide I understood were the psychosocial remediation or rehabilitation. And in that category is the cognitive remediation?

A. Correct. Cognitive remediation will be an important part of that. There are other parts that are typically outsourced these days to community providers by VAC, such as vocational rehabilitation would be a very typical example of that.

There are other types of psychosocial rehab that we engage less with even with community providers, because the nature of our population is typically such that often they're more independent functionally than some other mental health populations such as people with dementia or people with severe schizophrenia. But there are aspects of that PSR, psychosocial rehab, that are relevant and our clients do engage, for example, in vocational rehabilitation. We also try to connect, as best possible, with those community providers in order to have a shared care plan.

Q. And you gave us a moment ago when we talked about neurocognitive deficits, just again generally what the cognitive remediation process was. What is that again? Can you just help

us understand that a bit?

A. So cognitive remediation is a set of interventions to help people function best in relation to their cognitive challenges. And typically, cognitive impairments, using the word health organization terminology, would be attention problems, memory problems, typically shorter memory problems such as working memory problems and related function problems such as problem-solving, abstract thinking, and future thinking.

Now obviously each client may present with a different set of those neurocognitive impairments and many clients do not have them, but some do. And so we do risk screening for that and if we find ... based on that and based on the clients and families' reports that they're struggling with that we go into a deeper assessment for that and then we can implement the three main types of cognitive remediation often combined.

One would be restorative cognitive remediation and that would mean trying to actually improve their cognitive impairment. It typically works well for attention problems, often using software as well as the clinician engagement.

The second would be compensatory where we try to help the client bypass the cognitive problem rather than improve it. Often, that's what works best with memory problems, and that's

been published about a lot, including in the States, including with the veterans.

And the third would be regulative or metacognitive, which is usually a supplement rather than a standalone although there are interventions currently in the country being exposed just ... or focussing mostly on that. And that will be helping the client think about their challenges so that they have more control and, therefore, can perhaps more easily use restorative or compensatory approaches.

Q. You said ... I think we initially started talking about that in relation to head injuries or neurocognitive deficits from a traumatic brain injury perhaps. But you said obviously other patients without a brain injury can also have neurocognitive deficits. I take it if a person has PTSD they may have attention or memory problems, do I understand that correctly?

A. Correct.

Q. Okay.

A. Correct. So the same as with anxiety, depression.

Q. And the cognitive remediation would be appropriate for anyone with a neurocognitive deficit like that from whatever source?

A. Yeah, so we call it transdiagnostic approach, meaning it's not diagnosed, it's specific, although it has to be tailored. For example, a cognitive remediation for people with schizophrenia would be different to some extent compared to people with PTSD or people with persistent depression, or even people with attention deficit hyperactivity disorder, which I didn't mention, is also sometimes a comorbidity of clients we serve.

Q. We've heard, when we've reviewed Cpl. Desmond's records, that various healthcare professionals have recommended or suggested that he would have benefitted from a neurocognitive assessment generally. Is that something that can be provided at the OSI clinic in Nova Scotia or is that something that's outsourced?

A. So we can do some neurocognitive assessments, as I mentioned earlier, through our psychologists at the clinic. But if we need a full neuropsychological battery which requires specialized training of a psychologist, then we do ask their referral source, typically Veterans Affairs Canada most commonly to find that community assessor, and from my experience at the clinic, that has been quite forthcoming so it hasn't been challenging to find that.

(10:20)

But I must say during the current pandemic it may be more challenging because those types of very lengthy assessments, very detailed ones, may be challenging to do remotely unlike some other assessments and so it may be needed to do that in person.

Q. Okay. Understood. The pandemic has changed many things. But let's say even pre-pandemic, if patients needed a full neuropsychological assessment, do you have a sense of how difficult it is to find someone to do that or how many people are qualified to do it, for example, in Nova Scotia?

A. So pre-pandemic my personal experience at the clinic was that within a very few months that was done in the community based on a request to Veterans Affairs Canada.

I don't currently have any experience during the pandemic, other than one person who actually, to my recollection, was assessed this week by a community provider and so it still is available.

I do not know how many trained neuropsychologists are available in Nova Scotia or any other province or territory in Canada. The number is much less than the full number of psychologists obviously, and typically it would be a fairly

available statistic to access I think through the College of Psychologists because, as I understand it, psychologists self-identify on that website what is their scope.

Q. But your experience was when patients did need it, the wait was not inordinate, I guess, if I can put it that way?

A. Correct.

Q. All right. So the OSI clinic provides a wide variety of treatment interventions obviously for patients so I take it that there's a fairly broad interdisciplinary team of professionals that work at the OSI clinic?

A. Yes, there is. As I mentioned, there are psychiatrists, psychologists, social workers, nurses, occupational therapists, a family physician, a nurse practitioner, administrative staff, the manager, and a research and statistics officer.

EXHIBIT P-000264 - TELEHEALTH AND REMOTE MENTAL HEALTH SERVICES

Q. I'm just going to ask that we put up an exhibit, this is 264, and I'm going to ask to go to page 6 of that document and just maybe zoom in on the chart there. I was going to ask you how many of each of these professionals there are but I think we have this in the documents.

So looking at this document yourself as clinical director,

there are two other psychiatrists, is that correct?

A. There were until very recently. Right now there's only one other psychiatrist.

Q. Is that just a matter of filling the position or have you gone to just two psychiatrists?

A. No, we're still recruiting for the other position.

Q. I see, okay. And you have a full-time general practitioner?

A. No, he's part-time.

Q. Part-time, okay. And it would appear that there are four ... again, if positions are filled, four or three and a half, perhaps, psychologists?

A. Currently three. We're still recruiting for more. We may actually recruit for more than 3.5, but that's still in discussion.

Q. Understood. A nurse practitioner and then several other registered nurses. And if I'm counting correctly that would be six social workers?

A. Currently, to my recollection, there are more but again, Patrick Daigle could be exactly on top knowledge of the current. But of the vacancies and so on, so I will defer to Patrick on the actual vacancies currently.

Q. Very good. Okay. No, that's perhaps better for him to answer those questions. But in addition to that you also have occupational therapists and the recently recruited clinical team lead, is that correct?

A. Yes. Yes.

Q. The multidisciplinary approach, why is that beneficial for patients? Why is that necessary?

A. I would use an additional term "interprofessional" and in academic literature that's an important distinction, because a multidisciplinary team works as a group but each one does their own thing and they may or may not share information about the client. Whereas an interprofessional not just exchanges knowledge but supports each other and learns from each other.

So it's an interprofessional team that's crucial. Because psychotherapy, as I mentioned, is done across disciplines and there's learnings to learn from different professions but also from different personal backgrounds and experiences.

And the arrangement of diagnostic lens by psychiatry and psychology, a rehab lens by occupational therapy, psychotherapy lens by those therapies-advanced professions makes for, to my mind, a much better mix of care for the client.

And I should mention, the driver of the care is the client.

And so it's not just individually that the client leads their care and we empower them to do that and make decisions about that, also organizationally we have the client and family advisory council who informs us about their input to continue to develop and improve services at the clinic.

Q. I see, okay. So that council, that helps to advise you on improving services?

A. Yes.

Q. And how is that configured? Who participates in that council to advise you?

A. So the council is on a voluntary basis. We have a calling to clients and their family members to join. And currently we have military veterans, an RCMP member, and a family member of a military veteran on the council, and we continue to recruit for more and more members of that council.

Q. I see. All right. So your services are provided in Dartmouth and also in Cape Breton in Sydney. If patients, or potential patients, live elsewhere in the province, how do they access the service? Are there other ways that they can access the services?

A. So clients who live remotely or far away from both of our physical sites, can (1) drive in; (2) get care remotely

typically through video but occasionally we also use just phone if they are living in or working in an area where they don't have easy access to broadband internet.

They could also receive care more locally in their community and if they request that, we advocate for that to the referral source that ... be it the community occupational therapist or community psychotherapist or a community psychiatrist be involved in their care, and we work collaboratively with those.

So sometimes clients can have a psychiatrist at our clinic, a psychotherapist in their community or vice versa, and same with the other professions involved.

Q. Okay. So I'm going to ask you about a couple of things there. Just on that last point, we had talked earlier about engaging community health providers where there's a particular expertise needed, perhaps a service that's not provided at the clinic such as a neuropsychological assessment perhaps.

But setting those things aside, if I just happen to live in a rural area and I'm a patient of the OSI clinic, perhaps I'm seeing you as a psychiatrist, I want to engage with a therapist in my community just because it's closer, how does that happen?

I take it that's something that can happen, how does that happen?

A. Yes, it can and it does happen based on client requests. Obviously we go through a process of discussion with the client to understand with them the pros and cons, the advantage and disadvantages of a team that doesn't work organically together in one clinic, but we also make a point to message that we do that and it all is about the client's choice.

And if the client prefers a community provider we ... as I said, we would communicate that to the referral source and say that we would recommend that and we would defer to the referral source to find that community provider.

We do provide some recommendations or suggestions about what type of provider. For example, if the client requires clinically trauma-focussed therapy, one of those three psychotherapies I mentioned, then we would recommend that the referral source find a community provider who is trained to provide that type of therapy.

(10:30)

Q. All right. So, for example, if it's a veteran, let's say, and the referral source is VAC, is Veterans Affairs Canada, we'll talk about the intake and assessment process in a moment.

But if you determine that a patient requires trauma-focussed therapy, they're in a remote community, you would recommend to VAC the type of therapist that would be appropriate or necessary, based on the type of service that the client needs, is that correct?

A. Based on client's consent, we would suggest what therapies would be the most effective, and we wouldn't necessarily say only one modality because, sometimes, one tries one type of trauma-focussed therapy and it doesn't have enough positive effect or it could have some negative effects. And then the therapist would need to switch to another type of trauma-focused therapy if they need therapy. And so we, typically, we'd say that we recommend trauma-focussed therapy. Kind of prefers that in the community. We could also point to some indicators of which of the three trauma focused-therapies may be more helpful than the others. For example, if there's a clear moral injury aspect to the OSI, then we would suggest that perhaps cognitive processing therapy be considered, but we wouldn't be committed to that recommendation because, again, it's so complex and individual. Most importantly is that the client feel safe and comfortable with a therapy, develop the relationship, and then see, if one modality doesn't work, they

can switch to another. But, I would say, a trustworthy trauma-focussed therapy, both at our clinic or in the community, would have to be tried in at least two trauma focus therapies out of the three.

Q. Ultimately, though, it is the referral source and the client that makes the decision who they will see. You make a recommendation, what you think is appropriate, at the end of the day, though, it is the referral source and the client that makes that ultimate decision? Is that correct?

A. Correct.

Q. All right. Now when we talked about treating people in more remote areas, you made reference to telehealth, I guess, or using the telephone, and also using virtual sessions, I guess, or using the internet. So I take it that the telehealth model has been used longer. Is that something that your clinic has used in the past?

A. Yes, we have used telehealth. So telehealth, unlike the online care, is based on specialized equipment that we have at our clinic and have used all the time, and that is available also in other clinical settings such as hospitals and sometimes large public clinics across the province and, actually, across the country. And so when I came in late 2018, soon after, I

started to provide telehealth services, for example, to clients in Cape Breton, because I was based in Dartmouth and couldn't easily go back and forth, especially in the winter.

I must say that since the current pandemic, we've pretty much shifted all our telehealth to online, partly because it seems to be much more user-friendly to the clients so they don't need to go to a clinical setting in their community. They can do it from their home, their car, whichever place they have that's secure for them and has good enough internet. So broadband that's reliable.

Q. Okay. So the pandemic, as it has with many things, perhaps, has hastened the use of online therapy?

A. It does. And as we submitted, one of the quality improvement initiatives at the clinic that we've done and published about is that rapid shifts in the early period of the pandemic to online provisional mental health care, initially, near the start of the pandemic, to the vast majority of our clients. Lately, it's a bit more mixed. Some clients, now that there are more safeguards and more knowledge about the pandemic, currently, some of the clients do prefer to come into the clinics in person and we accommodate that with appropriate precautions.

Q. All right. So I'd like to ask you a couple of questions about that. I understand that, and you made reference to it, that you actually published a paper on the use of, I guess, the online model? Is that correct?

A. Correct.

EXHIBIT P000265 - SCHEDULE A - SHIFTING TO REMOTELY DELIVERED MENTAL HEALTH CARE

Q. I think we have that paper marked as Exhibit 265. Maybe we can just zoom into the top. This is a paper published by yourself and Mr. Daigle entitled **Shifting to Remotely Delivered Mental Health Care Quality Improvement in the COVID-19 Pandemic**. Is that the paper that you're making reference to?

A. Yes, it is.

Q. Okay. So can you tell us what your experience has been in shifting to a more predominantly online model, in part, out of necessity by virtue of the pandemic, but what you found and, from a clinical point of view, how effective that is?

A. So we have found that the majority of our clients are quite comfortable with this approach. They're forthcoming with that. The technical resolution is usually okay, sometimes even fine, because, in mental health care, it's primarily examination and intervention through talk, through communication, rather

than through a physical examination, intervention, then it's quite conducive. And there's enough previous research to support that, including from Canada, to support that remotely delivered mental health care is effective, efficient. Actually, there's some research showing it could even be cost-effective, which is less relevant for today, and it's user-friendly for clients and often for clinicians.

And so within very few months - I would say, a few weeks - we "on-boarded" everyone and I think they are important parties to always accommodate exceptions. So clients who don't feel comfortable doing this online and prefer in person, we accommodate that, obviously. Some clinicians with some types of interventions may have challenges, as I mentioned. Neuropsychological assessment may be more challenging. Obviously, that's outsourced for our clinic. But more often than not, we actually do pretty well with online care. And I predict - I may be wrong - that after the pandemic ends, we may not go fully back to in-person provision, but may continue to work in a hybrid model fully based on client choice.

Q. There are certain things, obviously, that require face-to-face meetings. If you were going to prescribe a medication for someone in the first instance, I assume would you

need to see them in person?

A. No, not necessarily, actually. For both psychiatric assessment and medication prescriptions, telepsychiatry, which has been done and published about for decades now in Canada and Australia and elsewhere, is quite effective. It's more some of the psychotherapies because the very fine nuances of non-verbal communication when someone is triggered, but dissociating, and so you may not easily see that unless you're very close to them, may be more challenging. But over time, psychotherapists seem to be getting better and better at doing that. And, interestingly, the textbooks are now coming in for psychotherapy, incorporating online, including in reference to the current pandemic. And so, you know, we just recently purchased a gold standard for group psychotherapy. It's a textbook. It's many hundreds of pages and it has a new chapter added to that about how to provide online psychotherapy for groups in the current pandemic.

So it's really incorporated worldwide into the toolbox of mental health care providers.

Q. I see. So not just individual psychotherapy but also group therapy can be done virtually?

A. Correct.

Q. There are certain forms of psychotherapy. I'm wondering, for example, about the eye movement desensitization. Is that something that, I assume, would have to be in person?

A. It's more challenging remotely, but it is being done remotely through self-tapping. There are different techniques to assist through that. And so we need more research published in the world to see how effective that is compared to in-person, but it does look promising to do that online too.

Q. Okay. So you said, during the pandemic, you moved, by necessity, to almost all clients being seen virtually? Did I understand that correctly?

A. Initially. And as the pandemic proceeds, over time now, we have more of a hybrid mix of some clients going back to in-person visits, but I can say, for my careload, so for the number of clients I provide care to, which is roughly about a hundred, currently, the majority are actually being provided care by myself remotely.

(10:40)

Q. And when the pandemic is ... when, I say hopefully, not if, it ends, you said that you don't anticipate going back completely to an in-person model, that you will continue to see patients remotely?

A. That's my prediction based fully on their choice, but some clients are saying that it's actually more comfortable for them to continue remotely because they live very far away from both sides, especially from the Dartmouth side where I mostly practice. Also because, timing-wise, sometimes it's just more efficient for them to not do the drive, even if it's only a half-hour drive to the clinic and back. And so that's what I do predict that we'll have a hybrid model for a lot of in-person and remotely delivered care base and client choice.

Q. And I would also assume that patients, that it can be a mix? You could see a patient in-person, for example, for one visit, and then see them remotely for a number of visits thereafter?

A. Yes, absolutely. And, sometimes, after a lot of remote sessions, the client may want to come in because they may have a form, a paper form, that's not digitalized. Most of them are now digital, but there are a few of those that are just in paper form. They don't want to send them, they want to actually bring them to the clinic and do them with me in real time so that I actually complete them and get their input, which is the way I practice. And so they would then prefer to do it in person, which is fine.

Q. So I'd like to ask you some questions about the process when a person is referred to the clinic, potentially, for either assessment or treatment. I think you made reference to this a moment ago, but someone being referred to your clinic may be referred for treatment, they may be referred for a disability assessment, or they may be referred for both. Do I understand that correctly?

A. Correct.

Q. Okay. Can you ...

A. And there are a few, the few less common types of referrals. For example, a second opinion. So a client may actually be in full mental health care, let's say, in the community. They may have a psychiatrist in the community, they may have a psychotherapist, maybe an occupational therapist, but they or their case manager at Veterans Affairs Canada may ask us to assess them to see, is something being missed? And so we would do that, too, with client's choice.

Q. Okay. So can you give us a sense of what each of those processes involve? So, for example, if a person is being assessed, or is being referred, I should say, for a disability assessment versus treatment, what happens?

A. Okay. So the first step would be triage which is a

connection with, typically, one of our intake nurses by phone. So the client has a 15 to 30-minute conversation with that nurse so that we have preliminary information beyond the documents sent to us by the referral source.

The next step, typically, but not always, would be intake, usually by the same nurse. That could be in-person or online or even by phone, as needed, and that would be a more extensive conversation to get more details of the experience of the client and to try to confirm and perhaps add to some of the information provided by documentation through the referral source. And then after that, there's a full assessment.

Q. Okay. And this is ...

A. And the full assessment would ...

Q. Go ahead, sorry.

A. And the full assessment would typically be by a psychologist or a psychiatrist, partly because, in Nova Scotia, only psychologists or psychiatrists can diagnose psychiatric diagnoses. And so, after that part, then we bring it to the interdisciplinary team meeting which occurs once a week. And together, as a team, based on client input, of course, we make some decisions about what could be the care involved? Is this care involved? An exception to care would be if the client at

the referral source have asked for only a disability assessment, meaning no treatment needs ... treatment request involved. We may still make treatment recommendations in a disability assessment - that is part of our professional scope - but, other than the disability assessment, we would not proceed with care unless the client and the referral source have changed their ask to us.

Q. Okay. So let's kind of break that down a little bit. So there's a referral initially. Let's say it's from VAC, from Veterans Affairs Canada. Do I understand you that, initially, it will say, We're referring this client for treatment or for disability, or both. The initial referral will suggest what they're looking for. Is that correct?

A. Correct.

Q. And there is a triage then, you said, by a nurse, by a registered nurse, most commonly?

A. Correct.

Q. All right. So if you can say, typically, when a referral comes to you, is there typically a significant amount of information and medical documentation that comes with it or is it sometimes very brief when it's first referred?

A. It depends. It's really person by person. Sometimes

we get a lot of information, especially if the person has been in mental health care previously and that documentation is available; for example, from another OSI clinic in the country. And if we don't get enough - let's say psychotherapy notes, the full complement of them, isn't available from the past - then we would ask, typically, the case manager from the referral source, sometimes directly to that provider that's in another clinic, to provide us more of that information. But some of the clients may have never been in mental health care, and so they're referred with some information based on their discussion with Veterans Affairs Canada or RCMP Health Services. There may be a few notes from an emergency room or from a family physician. And so it's a whole range of availability of documentation. It depends on the client.

Q. Understood. Can you give us a sense how often clients are referred to you that have never had a diagnosis, perhaps? I would assume it's more common that they have at least one diagnosis in the past, but I may be wrong about that.

A. Correct. It's a minority of clients who have had no psychiatric diagnosis in the past, or at least no mental health care, because sometimes, in the country, they have had some mental health care without a formal diagnosis other than a

working diagnosis of a depressive disorder, but perhaps no more than that. Maybe they had one contact in an emergency room, were prescribed there an antidepressant but, in an emergency room, it's quite difficult, especially if there's no psychiatrist working there, to fully diagnose whether it's major depressive disorder, or persistent depressive disorder, or substance-induced depressive disorder. Those are nuances that are difficult to tease out in an ER.

Q. Okay. So the information that you're provided is, it kind of runs the gamut. I understand that. And so, initially, at triage, what does the triage look like? Is that a telephone interview or is that an in-person interview with the nurse?

A. It's typically a phone conversation between the nurse and the client.

Q. Okay. And that is to determine, I guess, what the client is looking for and what might be expected of the clinic? Is that correct?

A. Exactly. It's some basic mutual expectations and some important, pressing information; for example, is there some urgency, from a client's perspective? The nurse, like any other clinician, would do at least a preliminary risk assessment even then to make sure whether there's a need for some more urgent

care. And if there's a need for urgent care, then they would inform the client how to go about that. They may even reach out to some urgent care services. That's an unusual scenario, but it does happen. More often, it's more about those mutual expectations giving at least a preliminary sense to the client what the process of the clinic is about, hearing from the client what they want from the clinic, what their understanding is, what the referral is about, and then trying to reach that common ground and scheduling them, or arranging for them to be scheduled, to an intake.

(10:50)

Occasionally, we do skip an intake and go directly to assessment. We discuss that in a weekly intake meeting where the nurses bring those clients who have those questions regarding skipping or fast-tracking into psychotherapy. Sometimes we do that too. So we bring that to the intake meeting and we decide whether, for this particular client, we could skip the intake. For example, if there's a thorough psychological or psychiatric assessment from the last year or so available to us on documentation, we may not need to spend the client's time doing intake because we already have quite informative documentation.

Q. Okay. So the triage will typically occur within a certain period of time from the referral being received by the OSI clinic, is that correct?

A. Yes.

Q. How quickly does the triage normally happen?

A. So, typically, within a couple of weeks. We aim for less and we often do do it much faster than a couple of weeks.

Q. Okay. So after that triage process and those mutual expectations have been done by the nurse, you say, typically, in most cases, it will go to an intake process. Is that correct?

A. Correct.

Q. And that will be at an ... you have intake meetings how often?

A. Once a week.

Q. So does that involve ... what does that process involve? Let me ask you.

A. So that intake process would be just hold the meeting where a variety of professions sit ... the manager and myself sit at the intake meeting too. And, by the way, in between the weekly meetings, we also discuss complex intakes so that we're on top of that if there's a pressing need. So just in between those meetings. And the intake evaluation, for lack of a better

word, with the nurse and the client would then be that longer conversation. Might take, occasionally, hours, if the situation is quite complex and there's a lot of background history. The nurses can also tease out more, some of the medication history, some of the psychotherapy history, because often that's quite important to learn from that history to not repeat things that may not have worked in the past. Obviously, that's re-evaluated during the full assessment, especially by a psychiatrist in regards to the medications, but we do go through that timelining, at least briefly, with the client. But the intake is done with the client. They're informed that this will be brought back to the whole team, and then a full assessment is likely going to be scheduled and they'll be informed when their full assessment by a psychologist or psychiatrist will be scheduled for.

Q. So let me just understand. There's a triage with the nurse that is typically done by phone, then do I understand you that sometime after that, there is a fuller intake assessment done with that same nurse that's probably in person and can take several hours?

A. Correct. Could be online rather than in person, depending on client choice.

Q. Right, okay. And those things that you mentioned; for example, getting a more ... a fuller psychiatric history, learning about the meds that the person may have been prescribed, and so forth, that information will typically be gathered during the intake assessment?

A. Correct.

Q. Okay. How long after the triage does the intake assessment normally happen?

A. Typically, within a few weeks, and it does range. And so it partly will depend on some priority because we do have, at any given moment, quite a few clients waiting to be triaged, intake, assessed, and so on, down that stream. And so usually within a few weeks. Occasionally, more faster if we think, as a team, that there's more urgency to doing the assessment.

Q. Okay. And after that intake ... well, the intake assessment ... well, perhaps I can direct you. Let's bring up Exhibit 261 again and go to page 11. So just at the top of that chart, the flow chart there, there's an intake assessment. It says, "RN, SW, or OT". So I take it that's "registered nurse, social worker, or occupational therapist". So the intake assessment can be done by any of those individuals, can it?

A. Correct, but, lately, it's primarily done by nurses.

Q. And, thereafter, the information that you've gleaned from that intake assessment is brought to an intake meeting, a group meeting? Is that correct?

A. Sorry, you were cut off.

Q. After the registered nurse gets the information from the intake assessment, that's brought to the weekly intake meeting, is it?

A. Sometimes. If the process seems to be fairly simple with the client then they just proceed with the intake rather than bring the client's issues to the intake meeting.

Q. Okay. So if we follow the chart down, if the client is seeking, potentially, treatment, or a treatment and a disability assessment, it appears that the treatment assessment is done by psychiatry, whereas, if it is solely for a disability assessment, it's done by a psychologist. Do I understand that correctly?

A. That was correct if the document was provided, but as ... often as things are dynamic. So, right now, because we have less psychiatry HR and psychology HR, and as because psychologists can diagnose as well as provide most care recommendations, other than in regards to medications, then they are also doing treatment assessments and treatment and

disability assessments, as are psychiatrists when we're available, but when a psychologist is doing, let's say, a treatment assessment, treatment and disability assessment, then we would also schedule, later on, if the client agrees, for them to see a psychiatrist to make sure that the physical health challenges that may impact on their mental health and that their medications are being addressed too because those two issues are not in the scope for psychologists.

Q. Okay. Is it common for the nurse, for example, who's doing the intake assessment, to have to either ask the client or VAC for more information, more background information, and more medical records?

A. It often happens. I couldn't tell you how often, but it is a fairly common occurrence, and not necessarily because of lack of effort on the referring sources part. Sometimes, there's lack of access for them; for example, for Veterans Affairs Canada, to some documentation, as I understand it, but perhaps if they would be available, they could give more information about that. But a typical example would be a private provider, both in Nova Scotia or elsewhere, whose progress notes, psychotherapy notes, may not be available and may take some time to actually obtain them, because for our

psychotherapy, the summary is helpful, but looking at fine notes of psychotherapy and what works and the nuances could be particularly helpful if they're to proceed with psychotherapy for the client.

Q. If clients are coming from another province - let's say they've been treated by an OSI clinic in another province or at Ste. Anne's Hospital in Montreal, that type of thing - would those records typically come with them at the first instance if they're referred or is that something that the team would have to seek out?

A. It's hit and miss. It depends, from my experience at the clinic. Sometimes, the full documentation comes; sometimes, part of it. Let's say only the discharge summary. Sometimes a very brief note. It depends. At the very least, we expect another OSI clinic to send a summary note on discharge, and a fairly detailed one, but, as I said, if the client received psychotherapy at that clinic, we often do request those psychotherapy notes. They can be in the hundreds of pages, so it's quite onerous to fax them, maybe not safe, and, therefore, sometimes they have to be sent after the fact by courier.

(11:00)

Q. Understood. Okay.

Your clinic has access to medical databases, I assume, that are used by Nova Scotia Health Authority, is that correct? I'm thinking of MEDITECH or OneContent?

A. Correct.

Q. And do you have access to both of those sources?

A. Yes.

Q. Would you access those sources for clients who are referred to you? Or would you need to access them typically?

A. Yes, typically always I would. An example would be the first source may not know the client had visited an emergency room a couple of weeks ago and because the referral was done three weeks ago but also perhaps because the client may not have thought it's particularly relevant.

A clinical example would be client comes to the emergency room with chest pain and the discharge diagnosis is a panic attack. We need to know that. Or the discharge diagnosis is ischemic heart disease. As a prescriber, I need to know because some of the medications I prescribe, could prescribe, may not be safe for that particular patient.

Q. Right. Okay. So it would be standard, then, to check both of those sources as part of the initial process with a client?

A. So it depends on where the client is residing. If they're in Central Zone Nova Scotia they wouldn't usually have a MEDITECH file. If they're outside the Central Zone they would. Often their documentation is also in OneContent.

Q. Understood. Okay. When that material is gathered, ultimately, looking at the flowchart we were looking at a moment ago. At some point the file is brought to the interdisciplinary team? Do I understand that correctly?

A. Correct.

Q. Okay. Can you tell us a little bit about that, what the interdisciplinary team meetings look like, how often they occur, and who's involved in them?

A. Okay, so IDT meetings happen weekly. They're required by Veterans Affairs Canada for all OSI clinics, to my knowledge. They're quite helpful. It's where the different clinical professions meet. All the team members, not just a representation, unless someone is on training or on leave. I attend them. The clinic manager typically attends them. The research and statistics officer also attends them because he has some valuable information to add to the mix.

And at that meeting each new client, once the assessment has been done, is presented by the person who did the

assessment, although student occasionally, with their supervision, if there was a student involved. After a brief presentation, typically a few minutes' presentation of what the issue is. Or issues are, I should say. Then we have a brief discussion within the team what would be the best way to go ... to move forward with this client, especially if the client is referred not just for disability assessment. Because if they are referred only for disability assessment we inform the client ... the team, we have a discussion but there's no care continued after that even if there are care recommendations in the disability assessment.

And we do also prioritize clients with psychotherapy, and so these days at the start of the IDT meeting we first discuss clients who the assessor thinks needs psychotherapy by our clinic or perhaps elsewhere and then we proceed with the other clients. The IDT meeting addresses not just new clients. It also addresses complex clients.

So clients are not necessarily doing well even though they may be well known to our clinic. So we bring them back to IDT to have a brief discussion. If we decide as a team that we need a more lengthy discussion we have what's called the post-IDT meeting after short break the same morning on the Wednesday. We

then have more nuanced, more detailed discussion about that particular client.

We also have done six months reports at the IDT meetings. These days we mention them but if there's no complexity involved, we mention it but we don't go into the fine nuances because although Veterans Affairs Canada requires those six months reports, when client is in our care, if the care is going well we don't necessarily need to discuss that with the IDT team.

Q. And do all of the professionals at the OSI clinic sit on the IDT meetings?

A. All the clinicians, yes.

Q. All clinicians? All right, so a person is referred for treatment. Let's say they may have a diagnosis from previous treatment. The determination about what they need, how they will be further assessed, those types of decisions are all made at the IDT meeting, are they?

A. I would say they're discussed and some ... what we would call dispositions are decided on. But always based on client input. So the assessor, be it the psychologist or psychiatrist, when they're assessing the client already have a discussion with the client about their preferences and they

bring that to the IDT meeting. But the IDT meeting decides on whether we could offer those services based on the client choice or no.

An example would be if the client wants TMS, the magnetic treatment, and we don't have that, then we would decide ... and we think it's appropriate, we would decide to do that referral out.

Q. Okay. And when those discussions are ... well, a person comes with, let's say, a diagnosis from a previous caregiver. You're aware of that diagnosis. I take it that whatever is going to happen you're going to want to make your own diagnosis at the clinic or ensure that you agree with the previous diagnosis? Is that correct?

A. Yes, absolutely. We don't start from scratch in the sense of not reading the documents. We do read all the available documentation. It's part of our information, but so is the encounter with the client. And we do sometimes re-diagnose, add diagnosis. Sometimes we do change diagnosis.

It's an unfortunate worldwide fact that in a psychiatric diagnosis durability across diagnosis is not great. So some research has shown across the world that using the DSM, the American classification that we use in Canada for psychiatric

diagnosis, reliability is very roughly only about 50, 5-0, percent of re-diagnosis, and that's across special populations.

So it is a profession where we work with our communication tools. We don't have laboratory tests for our diagnosis. That's how the profession has proceeded today and, therefore, we do have to ensure that we're on top of the current diagnosis as well as past diagnoses. So we occasionally have situations where there was a certain type of diagnosis in the past. Maybe there are no symptoms now.

When we look at the history with the client and the documents occasionally we may not be clear why that diagnosis was made because we don't have enough evidence for that. So we would put in our report a question mark and say something like, Major depressive disorder per history, query, question mark. Was it actually major depressive disorder? Could it have been something else? But it's ... the times have changed for the client. So we can't confirm or refute that.

Q. When those initial, I guess, decisions are made about what might be necessary for the client is there a particular clinician that would take responsibility for that patient? Be the primary caregiver or the person responsible for that patient?

A. Yes. So we have what we call primary clinicians. Typically, but not always, they would be the psychotherapist if the client is assigned a psychotherapist by our clinic. If the client has no psychotherapist at our clinic, then it may be an occupational therapist if the OT is working with that client. Or it could be the psychiatrist. It would not be the primary care provider at our clinic unless the primary care provider is left as the only healthcare provider at our clinic, which occasionally happens.

When that happens ... is that we don't close the file but then by agreement with Veterans Affairs Canada the client has a year with that primary care provider to find a community primary care provider. But yes, the most common occurrence is a psychotherapist is the primary clinician.

Q. And I think in some of the other materials we've been provided there was some discussion of the MRP model, or most responsible physician. Is that a change in the approach of the clinic?

A. That is a change that we instituted soon after I joined the clinic in late 2018 and we think of it as another safeguard to add to the mix of the clinic's work so that even if the psychiatrist may not be involved much anymore with the

client ... let's say the medications are stable. If the family physician in the community was prescribing them now because it's going well but the psychiatrist would still be available to the client and the team members providing, let's say, psychotherapy or occupational therapy to the client as needed. Even if it's only every few months.

Q. Understood. Your Honour, I don't know if you want to take a short morning break or if we want to keep going.

THE COURT: We probably could. Dr. Rudnick, we would normally take a mid morning break sometime around 11:15, and we're pretty close to that time. So perhaps we could take a break for maybe 20 minutes. We'll come back at 11:30. That's good for you? All right.

A. Thank you, Your Honour. That's great.

THE COURT: Thank you.

All right. Thank you, Counsel. We'll adjourn till 11:30.

A. Okay. Thanks.

COURT RECESSED (11:11 HRS.)

COURT RESUMED (11:30 HRS.)

THE COURT: Thank you. Mr. Murray?

MR. MURRAY: Thank you, Your Honour.

Dr. Rudnick, we were talking before we broke, about I guess

the general assessment process for clients and ultimately the discussion that's had at the IDT meeting. There is a formal assessment report, is there, done for each client or each prospective client?

A. Correct, yes. So typically it's been what we call a narrative form. So that would be a text of usually a few pages with the relevant history, the examination results, the diagnosis, and also the more general impression, including what we call a formulation - I can explain that if needed - and then suggested recommendations, which is the plan.

For disability assessments it's also a special form by Veterans Affairs Canada, what we call in short the Pen form, P-E-N, and that also goes to Veterans Affairs Canada for disability assessment. Now sometimes the narrative is inserted into the Pen form. It's now digital. So it can be expanded practically infinitely. Sometimes it's a narrative report that refers to the Pen form with a cross-reference, and VAC accepts both formats.

Q. And that reporting back to the referring agency, say it's VAC, that's something that's required, is it?

A. Yes, for all assessments it's required and it's also medical, legal, and clinically the safest way to operate.

Q. Okay, so if a client has been referred for treatment and it's determined that that's appropriate and that you have treatment that you can offer that client, obviously a decision will be made in consultation with the client about what forms of treatment are appropriate. Is that correct?

A. Correct.

Q. All right. Are there particular ... depending on the nature of the treatment I assume there are different wait times for a client to be able to access those forms of treatment?

A. Yes, so we should distinguish psychotherapy from occupational therapy from psychiatry from primary care. Those are the four buckets, the main types of ... I would say professional interventions we provide and we do have sometimes weekly for some of those interventions. But we also prioritize.

So both at the intake meetings as well as the IDT meetings we currently have a system of one, two, or three priority level, and the ordinary situation would be when a client is a priority three, meaning that either they currently already have care or enough support and they're not in particular crisis and, therefore, they'd be a priority three and if there's a wait time they would be on the waitlist.

If they're a priority two, meaning there's some more

pressing need, then we would jump the queue for them and try to get them in the very next few weeks into the psychotherapy or psychiatry, whichever they may need or the most pressing need is.

It's rare for us to have someone in priority one, which is the most pressing and urgent. It does happen, but as I mentioned by Veterans Affairs Canada mandate, OSI clinics are not urgent care clinics. So if someone is currently actively suicidal or actively violent or extremely intoxicated by substances and not willing to work on that right now we would try to hand them over safely, their care over safely, to more urgent services, and there are those in Nova Scotia we can connect with.

Q. Okay. So if someone, for example, is actively suicidal, in your estimation, they would be referred elsewhere for assistance that ... because you're not a crisis centre. Is that ... that's correct, is it?

A. Correct, but I would say beyond referral we would try to do a handover. So a handover in clinical terminology is when there's an actual connection. It's not just, you know, doing a referral and hoping that the referral source ... that the referral agency actually make it happen. We connect, let's say,

with the mobile crisis services or an emergency room, and if the client is cooperative, then we would do the handover.

There are rare exceptions, not during my time at the clinic, but there theoretically could be where the client is not cooperative. Then there are legal measures if there's a risk to self or others to ensure safety of them and the public. But I've not been involved in that since I've come to Nova Scotia.

Q. If a client presents, let's say, at the triage stage or at the intake stage and the ... I take it that the nurse who conducts those processes will attempt to gauge if there is a suicide risk, will they?

A. Yes, absolutely. It's part of the professional responsibility and of quality assurance that if there is suicide or other self-harm risk or other types of self-harm risk or risk to others we would engage clinically at the minimal level in order to ensure safety if need be; handover or de-escalate the situation, which all of our clinicians are trained and capable to do.

Q. Are there particular tools or instruments that your clinicians use to determine suicide risk?

A. Yes, there's a standard Nova Scotia Health Authority form, which is like a checklist, quite detailed, that every one

of our clients goes through during their intake, and if intake is skipped - let's say there's no need as we mentioned earlier, only triage - then the assessor may do that intake or the assessor may ask that triage nurse to come in just before the assessment and do that risk assessment for them.

Q. Okay, so even if the intake, the formal intake assessment process, can be skipped that process still takes place, that suicide risk assessment?

A. Yes, and it's for quality assurance, including chart audits, to make sure that is not missed.

Q. In the same vein, is there an assessment done to determine if the client may pose a risk to others to harm others or commit an act of violence toward others?

A. So unfortunately, the research in the world has not formalized that as much as risk to self. Previously in another province as a chief of psychiatry I was involved in trying to put such a measure in place to complement suicide risk assessment. It is not easy because there are no gold standards for that. There's different tools. Each one has it downsides and upsides.

But every clinician engaging with the client does that, an assessment of risk to others, not just risk to self. And I

mentioned just a moment ago that risk to self is not just about suicide. There's also unintentional risk to self that has to be factored in. So we're ensuring that that's not missed, too, when ... for example, people, because of memory issues, forget to turn off the stove and can burn down their home. And so we need to assess for that, too.

And same with unintentional risk to others. Driving under the influence is perhaps unintentional risk to others. So we assess all of that. Some of that is more formalized, like the suicide risk assessment, some less formalized but still clinically possible and done.

Q. If the prospective client has a domestic or intimate partner is there any discussion about ... or any thought given to risk to the partner depending on the condition that the person is dealing with?

A. Yes, absolutely. Whenever there's a suspicion of domestic violence we do a more thorough assessment, all the clinicians involved at any stage. Of course the caveat is that if you're only talking to the client, then the narrative may be somewhat one-sided sometimes depending on their perspective. They may be withholding information.

(11:40)

More often than not, their perspective is a bit narrow because it's coming from their lens, from their aspect, and so we do encourage clients to involve their family members, especially family members living with them like spouses, to engage with us with them together for at least two purposes. One is for collateral information. That's a technical term that means that the family member provides us information about what they think is going on and their lived experience of the situation. Also some history. They may know the client for many years and they may remember some of the history that the client sometimes doesn't remember. Even medication sometimes.

And the second purpose is to do what we call a psychoeducation with the family member to inform them, communicate to them with the client's permission what is the relevant mental health challenges, what is the interventions that may be most helpful in the client's situation.

Q. Okay. If the client consents, then if there is a ... for example, a domestic partner, I take it, then, the intake assessment might involve a discussion with that person, would it?

A. Sorry, you were cut off.

Q. If the client consents the nurse conducting the intake

assessment would want them to talk to the domestic partner, again, if the client consented?

A. Yes. I would say that during intake it's not perhaps the routine to involve the family member, although it often happens if there's a need. Whereas during the assessment, and even moreso after the assessment, once there's full engagement to the client and maybe they're feeling safer with the clinic once they've met people a few times at the clinic, then absolutely, we repeatedly ask them to consider involving their family member, at least the person they live with.

Q. Okay. I just wanted to ask you. I'm looking at Exhibit 261, and there's material provided about the assessment process. And obviously, apart from assessment for treatment or disability, the document seems to suggest that there can be assessment for other things. One in particular that I'm curious about, the document says that "occasionally clients may ask the OSIC to complete an assessment on behalf of their provincial firearms officer". That's at page 22 of Exhibit 261. Do you have to do that? Or are you asked to do that very often?

A. I have yet to be asked to do that. I've not been asked to do that for the more than two years I've been at the clinic. Specifically only for that finding. It's maybe a

possibility, and Patrick Daigle may talk more to that about, Is that something that Veterans Affairs would ... kind of would support us doing just that rather than any other part of care and assessment for the client?

Again, I have no experience with this particular assessment as a standalone.

Q. Okay. Through the treatment process is there ... if a person is suffering from, for example, PTSD is there a discussion of weapons or firearms or whether they possess weapons or firearms?

A. Yes, always we discuss availability, accessibility to firearms as part of our violence risk assessment, and as if there are firearms, then the clinician involved would engage in some education about safety. And if they have a safety concern, then they may trigger an escalation of the process. And in that situation, even if the client is in disagreement, if there's a clear suspicion that there's danger to others, then that disagreement of the client can be overridden.

It's very unusual that that occurs, especially with our client population, but it is possible.

Q. So when a treatment plan is established, I guess, or agreed upon, typically is there a timeframe set out that you

anticipate a particular treatment modality may take? Appreciate that it can change, but at the outset do you say this is something that we think will take eight months or 12 months or what have you?

A. Yes, absolutely, and I should also maybe explain a bit more generally. So we have moved now to a collaborative care plan process where from early on there's a joint care plan for the client, the team, that referring source and community providers, if they're involved. So from early on the client's goals are there and the barriers or the challenges to achieve those goals are there. The intervention is offered and implemented. The outcomes to date are there, and we revisit that.

We're now broadening that to the whole client population of the clinic. We started that more for the more complex situations, and the idea is that in that care planning process and ongoing we are informing the client what we expect are the timelines.

So typically for medications, for psychotropic medications, we're talking within weeks to months of seeing sufficient outcomes including whether the medications are not working and then a switch or an add-on and so on.

For psychotherapy it's a bit of a longer timeline, but we typically wouldn't talk about many years. We talk about quite a few months to a very few years and, again, revisit that at least every half-year.

For occupational therapy, again it's months to years, and for primary care it's ongoing, obviously, until the end of ... or the clinic, if they're getting primary care at the clinic and one year later after all mental healthcare ended at the clinic unless they find a primary care provider in the community before that one year after end of mental healthcare occurs.

Q. Okay, so let me ask you about those kind of individually. So for medication you prescribe meds that you think are appropriate and you typically will ... it'll be a period of weeks or months to assess if the medication is working as you had hoped?

A. Yes. I want to explain that the different diagnoses respond in different timelines to the medications, the psychotropic medication, particularly antidepressant medications. And there are four medications that are clearly evidence-based for PTSD, especially military PTSD, and then there are others. So we sometimes use others in order to help the side effects if the four have too many side effects for that

particular client.

But PTSD responds slower than major depression, for example. If we start an antidepressant and we gradually increase the dose typically within a few weeks to very few months we see if it's working well enough or not for major depression whereas with PTSD it may sometimes take twice the time.

And so we psychoeducate the clients and families on the need for some more patience with PTSD because it does typically take longer to take effect.

Q. It's my understanding, correct me if I'm wrong, that with PTSD the medication is basically symptom management and it's the psychotherapy that is ultimately treating, I guess, the post-traumatic stress disorder itself. As the client goes through psychotherapy for PTSD is it sometimes necessary to adjust the medication, to try different meds to see if they're working?

A. Yes, absolutely, and the mainstay is the psychotherapy, the trauma-focussed therapies for PTSD, but the antidepressants that are sometimes combined depending on patient preference and also severity of symptoms, they are symptomatic. But that's true, actually, it seems for pretty much all

psychotropic medications for all mental health conditions. We don't address the root cause. We address symptoms and we can achieve full remission for some conditions.

With PTSD it's not usual to achieve full remission of symptoms for along just with medications, but some patients do prefer to stay away or just discontinue eventually psychotherapy and just take their medications or not even that.

So the way I formulate the wording about medications for PTSD currently is that they're a bit of a safety net. If the symptoms are severe they can help with depressive symptoms that are sometimes part of PTSD. They can help quite a bit with anxiety and they help sometimes process the therapy better, the psychotherapy better. So the person is not as easily triggered and can follow through with some of the psychotherapy.

(11:50)

In some situations that is not true. So there's very well published research on panic disorder which many people with the OSI have where the combination of antidepressants, which help with anxiety, and cognitive behavioural psychotherapy is no better than just cognitive behavioural psychotherapy. So it depends on the condition, but that being said, if someone has severe panic attacks and therefore they're staying at home and

being agoraphobic and the psychotherapy is just not getting traction, because of that, then we will try to help them with medications.

The one type of medication we very much try to stay away from, when possible, is the sedatives. So benzodiazepines and what's called Z-drugs. Benzodiazepines would be the Valium family, Z-drugs like zopiclone. They're fairly similar. They work on a similar ... on the same receptor in the brain, and unfortunately, they're not only sedative, they worsen short-term memory. They decrease deep sleep, that part of the sleep, and they're addictive. And so even though they help in the short term, we want to try to get people off of those and if medications are needed, try to use the antidepressants instead.

Q. The second category of drugs that you attempt to avoid, one of the drugs in that category you said is zopiclone?

A. Yes.

Q. Okay. And it has potentially addictive side effects, does it?

A. So it's similar to the benzodiazepines, the Valium family. Although different, it works on a different part of what's called the GABA, G-A-B-A, receptor in the brain. So it's not as addictive, but over time it's been well shown in research

that people take a Z-drug like zopiclone over time. After a few weeks, a few months, it's less effective, which is part of the tolerance, part of the general addiction problem, and therefore to be still effective for sleep the dose needs to be increased.

And those medications are also ... especially the benzodiazepines like Valium. They're counterproductive for the psychotherapy. So people like David Barlow in the States have shown repeatedly that if you combine benzodiazepines with cognitive behavioural therapy the cognitive behavioural therapy is less effective. And we do try to stay away and educate the clients. But with some clients, they are what's called legacy patients. This is a standard term in medical genre where they already come with high doses of the opiates or benzodiazepines and then there's a complex process with their permission to try to reduce and hopefully eliminate those drugs.

So it does get complex and that's part of the inter-professional teamwork to work together with a psychotherapist to try to clear the way for the psychotherapy to be the most effective.

Q. If a client is engaging in psychotherapy, one of the trauma-based therapies for PTSD, is there typically a timeframe over which that will be administered, I guess, or the client

will engage in that?

A. Yes. So trauma-focussed therapies take quite a few months, sometimes more, if we're talking about complex post-traumatic stress disorder. Even non-complex, meaning there's not necessarily developmental trauma but there are many traumas.

So typically for many RCMP officers who have done general duty, and often for military veterans who've done a very traumatic deployment or many deployments, there are many traumas involved. So with a trauma-focussed therapy such as prolonged exposure or cognitive processing, we need to process each trauma or do what's called cluster traumas together which has been shown to be somewhat effective.

And so if a person has experienced many deaths of military peers and then also has experienced severe poverty to the point of starvation of locals in your deployment - and I won't go into more visual examples to not stress the audience here today - then it's very difficult to go one trauma at a time. Because some people have hundreds of traumas they've experienced. And so to do this well, sometimes the therapist has to cluster those traumas together. It seems to be effective. There is some research. We need more research to show how effective clustering is, but you can imagine if that's the situation with

a client, then we're not talking a few months of therapy. If they're willing to proceed with full therapy it may be in the years of therapy rather than in the months of therapy.

Q. Can a client continue almost indefinitely with therapy if it's deemed that it's continue to be necessary?

A. Yes, so we're mandated to continue working with clients as long as they need that and want that. The thing is that after a while some clients find it very difficult to tolerate more and more and more exposure even if it's in therapy. Because it's quite triggering, and obviously, there are benefits to that. But the stress related to that ... and although with therapy they're learning to do relaxation training and to do grounding, all of those preliminary techniques to get to the trauma focus. For some people it really is very difficult.

And so the therapists can either shift with them at that point to do some less triggering therapy in the interim and there are many other things to address often, including some meaning-making - this person is now trying to build a new life in the civilian world - and there are special techniques like acceptance and commitment therapy that can help with that. Some people just decide to take a break, some clients just take a

break from all therapy just to take a bit of a breather from that stress.

I should mention that trauma-focussed therapy typically is those three stages ... the preparation part, which is learning to do relaxation and grounding, and then the second part which is the trauma-focussed, and the third part if they proceed through the other parts well is the meaning-making and give some closure. But it doesn't have to be linear. It could be, if need be, jump across the stages rather than the first and then the second and the third. But typically to get best outcomes it'd be preparation, trauma-focussed, and closure with meaning-making.

Q. Okay, and so it's not unheard of, then, for a client to engage in trauma-focussed therapy, take a break, and then re-engage with it at some point later in time?

A. Yes, absolutely, including if their first trauma-focussed therapy didn't work as well or addressed well some traumas but not others. So they may try prolonged exposure therapy and it may have worked with two or three of their traumas but hasn't made much of a difference to a third, fourth, and fifth trauma for whatever reason. They may take a break or immediately proceed to, perhaps, cognitive processing therapy

for some more generalization and perhaps to address other aspects that prolonged exposure is not the best, such as possibly moral injury.

Q. Is there a point in time, I take it, then, when the clinician and the client will decide that their treatment is coming to an end when they ... either they don't want to participate in it anymore or they're done?

A. Yes, absolutely, and now typically in psychotherapy they ... timeline is discussed from early on and the expectation of when it may end, the therapy is discussed early on. But things do change and sometimes additional challenges are uncovered by the therapy. Sometimes an OSI may develop into complex-PTSD. It's uncovered that the person doesn't only have an OSI they actually also have developmental trauma from trying to but they may not have communicated that early on.

Once that's uncovered, then there's more work to do that's a bit different in focus, and we have the mandate to continue to work with the client on the developmental traumas if need be. Because if we don't what happens is that it complicates the recovery from the OSI.

Q. If a client then presented with post-traumatic stress disorder and it was determined, for example, that they had if

not a full personality disorder, that they had personality traits that perhaps complicated their picture, you could ... if I understand, you continue to work with them on those personality issues?

A. We could. We could do it in-house or we could also outsource. There are specialized programs in the province to help people with the very severe personality disorders. We do some of that work such as our dialectical and behavioural group skills training but it's more general, not just for personality traits. It's also for emotion dysregulation in general.

But if somebody is identified with a severe personality disorder as a comorbidity we may want them to engage in parallel with, for example, the borderline personality program in the province if they have borderline personality.

(12:00)

Q. Okay. And that's something that the client and the clinician can discuss and determine what the best course is, going forward, I take it.

A. Yes, absolutely.

Q. Right. When it appears that ... you'd said a moment ago, and perhaps you can clarify for me, if a client leaves, the file is held open for a year, did I understand you correctly?

A. No. If the client has ended their mental health care at the clinic, all aspects of that, but they still have primary care at the clinic by the family physician or the nurse practitioner, then their file remains open for up to a year with that primary care provider. They're expected and supported to find a primary care provider in the community during that year.

Q. So if a person is, let's say, finished with their psychotherapy, but they're continuing to see a primary care provider at the clinic, they have a year to get established with a family doctor in their local community?

A. Yes, or nurse practitioner.

Q. Or nurse practitioner. And the OSI clinic assists them in that?

A. We advocate. We may be creative in finding some pharmacare providers who are still available, but we cannot guarantee. It's not in our mandate, nor in our resources. It's ... now we try to go above and beyond and, to my understanding, the referral source doesn't necessarily also have access to those primary care providers. It's really a provincial matter. So we try to at least ensure that those kinds are on the provincial waitlist for primary care.

Q. Okay. Do you have a sense of, the clients that you

have, especially those that are perhaps leaving the Canadian Armed Forces and are VAC clients, how many of them come to you with family doctors or how many of them have experienced difficulty in getting established with family doctors?

A. I don't have precise stats, but my impression is that many do not have a primary care provider in the community, which was one of the rationales, to my understanding, why primary care was added to our clinic.

Q. I see. All right. And when a client transitions to a primary health care provider in the community and is basically finished with the treatment that they're going to receive from the OSI clinic, has it ever happened that they are re-referred, for example, by VAC, if they need additional, say, maintenance on PTSD symptoms? Something like that? Does that happen?

A. Yes, absolutely. For whatever reason. It could even be a new development. Maybe a different mental health challenge. If it's recognized by Veterans Affairs Canada, they can refer clients to the community, and for the first three months after closing the client's file fully, if they're referred back to us for whatever reason, then we fast-track that rather than start from scratch. Although, even if it's three or five years after we close the file for a client, obviously, we

have the documentation. So even if it's not fast-tracked, the referral, there's less preparatory work to do because we, by then, know the client quite well.

Q. Okay, sure. You said earlier in your evidence that you are providing services to family members if their, I guess, situation is related to the client's problem? I'm not putting that very well, but do I understand that correctly?

A. Yes, you do. And, yeah, I think you put it well. It has to be shown that if the family member improves their mental health, that would improve our client's mental health. So we don't accept family members unless the client is already being provided care by our clinic. And we also offer, as does the community, with VAC support, couple counselling, if needed, for a client and their spouse if that's clinically indicated.

Q. Okay. So is that provided in-house or is that through the community?

A. Both.

Q. Both.

A. We have limited resources for couple counselling, but we do provide that, if needed. And if our capacity is full for that, at that particular moment, then we ask the referral source to find the solution in the community and my experience is that

they usually do.

Q. All right. One question, just kind of related to things we've talked about before, but the clients that come to you that are ex-military, do you have a sense how many of them ... We've talked about substance abuse, obviously, and that is a comorbidity. Do you have a sense of how many clients use medical marijuana, either prescribed or on their own, as their own form of treatment?

A. So I'm going to distinguish medical from recreational.

Q. Yes.

A. So if we put those two together, many do. That is based on the disclosure to us. Maybe even more do without disclosing to us. And we are fairly clear that according to the research to date, there is no strong evidence to support cannabis, be it medical or recreational, for mental health purposes. There's actually research to suggest that it may worsen some mental health issues. For example, THC cannabis can trigger panic attacks and, occasionally, it can tease out a psychotic disorder. It can, in a sense, cause either a relapse or a first onset of psychotic symptoms. So we educate our clients that it is a legal substance, and so they can use it either medically, if that's prescribed, or recreationally.

So we work with them. We do not exclude clients from the clinic who are using cannabis. We continue to work with them and try to optimize their care, educate. Sometimes even we use motivational interviewing. But there are circumstances when it's helpful and we recognize that with the clients. So, for some chronic pain, especially CBD cannabis seems to be effective, based on the research and many clients' experience. And so, and there are medical conditions that are quite unusual for our clients, but things like closed-angle glaucoma and a few other medical indications where it's absolutely indicated and it's been helpful for decades.

Q. Okay. All right. Doctor, I think we have a document. I just wanted to ask you about Exhibit 264 which is, I believe, a number of - we've talked about some of these - but a number of the changes that have been implemented more recently at the OSI clinic. And, as I said, we may have talked about these, but the first of these is the telehealth and remote mental health services model. So we've talked about that. That's a more recent change and, in particular, precipitated by the pandemic? Correct?

A. Correct.

Q. And the second of these in this document is the MRP,

or most responsible physician model of care. And you said that you implemented that recently or you and Mr. Daigle?

A. Yes. We implemented that soon after I joined the clinic.

Q. All right. The third of these is a category of triage and intake. Have there been recent changes in the triage and intake process?

A. We reinstituted, in the last, perhaps, year or so, the intake weekly meetings. I think they were happening before my time and then, even before my time, they were put on hold. So we re-instituted that. The triage proceeds fairly similarly. Patrick Daigle could probably talk a bit more about the nuances, about the collectivity, for triage and intake between the referral source and the intake staff at our clinic.

Q. Okay. And that's fair. We'll leave that, perhaps, for him. And the next one also may be better for Mr. Daigle to talk about, but accessing records from other clinics. I see from this that you have developed a checklist for referrals. That's something new at the clinic, is it?

A. Correct.

Q. The next is the OSI clinic team. And, again, we're going to leave that for Mr. Daigle to talk about. And, finally,

there is a ... oh, there's two, actually. The quality assurance and quality improvement committee. That's something new at the NS OSI clinic, is it?

(12:10)

A. Yes, it is. It's something we instituted in the last year or year and a half, and we have a structured process for any new quality project, be it quality assurance or quality improvement, that we have a format to go through so that we're trying to make sure we're not missing aspects of that quality project. And an example of the quality assurance projects could be medication reconciliation which is standardized across the Health Authority. And so we're just part of that. But we need to make sure that when a client comes to the clinic, we're on top of all the medications they're taking. Not just the psychotropic medications, but physical health medications too. So there's a nurse involved and there's the physician involved that make the distinction between what's prescribed by us, what's prescribed externally. And so that keeps it safer. And a quality improvement example would be that rapid shift to remote care.

Q. Very good. And the last of these - again, we've spoken briefly about it - the client and family council, which

you mentioned in your evidence, and the logic model. The logic model is what?

A. So the logic model is a way to communicate and clarify what the clinic does. It's a standard approach in business studies and our organizational work. And so we've completed the logic model just in the last month or two for the clinic. It took a while because of the pandemic. And now moving on to the next phase of further clarifying care pathways in a structured way in patient journeys. That's a more advanced level for which we're quite hopeful about. And, again, input from clients and families is invited to that and the client and family council are a part of that input.

Q. Okay. Very good. Thank you, Dr. Rudnick. Those are my questions. Other counsel here may have questions.

A. Thank you.

THE COURT: Thank you. Ms. Ward?

MS. WARD: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. WARD

(12:12)

MS. WARD: Good afternoon, Dr. Rudnick. My name is Lori Ward and I represent the Government of Canada and that includes

Veterans Affairs and Canadian Armed Forces. I just have a few questions.

A. Hello.

Q. You told us you began your work at the clinic in late 2018. Is that right?

A. Correct.

Q. And we understand that, particularly since the pandemic, that online health care may have come a long way, but we also understood that you had, or the clinic had, telehealth in place from its inception, I believe. Is that correct?

A. Correct.

Q. So understanding that you weren't working at the clinic in 2016, can you tell us how telehealth would've operated then? This may be a question for Mr. Daigle, and I don't know, but are you able to comment on how telehealth worked since the clinic's inception?

A. To my knowledge, it was available. How much and often and for what was it used, I do not know.

Q. Okay, thank you. I think you mentioned that it required specialized equipment though.

A. Yes.

Q. What would that have been?

A. So it's screens and special, I think it's like a close-circuit TV that the Health Authority supports. I do think some of that equipment still exists somewhere, but many have moved to the more online. But it cannot be done at home for a client because it is actually secure equipment that's available only at the Nova Scotia Health Authority sites.

Q. Okay. So the patient couldn't be in their house, as we do today on Zoom or something. They would have to go to a Nova Scotia Health Authority facility. Is that right?

A. Correct.

Q. We talked a little about the neuropsychological assessment and I understand that that's somewhat of a lengthy assessment to be done. It can take more than one day. Is that correct?

A. Correct.

Q. And so a patient, to have such an assessment, would have to travel potentially to where a provider was who could do that assessment. Is that right?

A. To my knowledge, that's the traditional way. I have not yet seen a neuropsychological assessment done online. It's theoretically possible. In practice, I would expect it's quite challenging because some of those steps are still not fully

computerized. Many are. So it may limit the neuropsychologist. And I would defer to neuropsychologist experts on that, but it seems to me it would limit them in the types of steps they could use when they're doing the testing online remotely.

Q. Thank you. Are you aware, are most of the specialists who do neuropsychological assessments, would they be located in the HRM area or in central Nova Scotia? Are you aware ... or can you comment?

A. I don't know but I would expect so, yes.

Q. Okay. We've heard a lot of evidence about the inpatient program at Ste. Anne's Hospital in Montreal. And you're familiar with that?

A. I am and I toured it with Mr. Daigle.

Q. Okay. And so what we heard before was that inpatient treatment such as at Ste. Anne's would be for the most severe and/or complex patients. Is that your understanding?

A. I think it depends on what complexity we're addressing, there are different aspects of complexity. If we're talking about the most severe symptoms, then I would say not necessarily. If we're talking about the most severe destruction to daily functioning, then it seems to me, from what I know about the Ste. Anne's program, that yes, because they have in-

house rehabilitation.

Now that being said, as a psychiatric rehab expert, I would say that the best rehab occurs in natural environments, but there could be preparation in a residential inpatient setting such as, for example, if the person is so cognitively impaired that they need some hands-on help to learn cooking skills or laundry skills and so on. That's quite unusual for our client population but it does occur.

More often, when our clinic refers clients to what we call residential settings, it's more for concurrent disorders. A concurrent disorder is when there's both a significant mental health challenge and the considerable substance use disorder. And there's some in the country, some programs like that that have been providing that concurrent disorder care for clients.

And you can imagine, if someone is severely substance using, it's very difficult to proceed with their psychotherapy, or even medications, because they may be intoxicated, forgetting and so on, and those residential programs specialize in addressing both issues together within a few months. To my knowledge, St. Anne's is not a concurrent disorder facility. It's more like a residential or inpatient rehabilitation facility.

Q. Yes. And we've heard, as well, that Ste. Anne's requires a patient to be off of substances before they arrive there. Is that your understanding?

A. That's my recollection. And that, again, is not the way a concurrent disorder facility works.

Q. Thank you. Do you refer patients to Ste. Anne's inpatient program?

A. I have not.

Q. We talked earlier, or you gave evidence, on who the clientele of the clinic is. And that is some current CAF and RCMP members as well as veterans and former members. I'm wondering, where would an employee with an occupational or operational stress injury, such as a paramedic, go for such treatment in Nova Scotia?

(12:20)

A. They would use either the Health Authority or private providers. To my knowledge, there's no provincial or national framework to support them similarly to RCMP and military veterans, but there is an emerging initiative, I think led by the University of Saskatchewan, to address that population. So first responders meaning non-RCMP police, paramedics, firefighters, coast guards, and others.

Q. So there's presently no entity in Nova Scotia, like an OSI clinic, for those people.

A. Correct.

Q. Mr. Murray asked you about the length of treatments or potential treatments and you talked a bit about various treatments taking months, or many months, or months to years. I'm wondering ... and he asked you if some patients could remain with the clinic indefinitely; you said yes. Are you able to comment on your observation of the longest duration that a patient has been with the clinic?

A. Since its inception, we have some clients who've been with the clinic since 2016 and, to my knowledge, also based on touring other OSI clinics ... more veteran OSI clinics - some of them have been in place for more than a decade - have some clients who have been with them since their inception.

Q. And is it true that some patients never leave the care of such a clinic?

A. True. It's a minority of clients because we do try to help people move on, do better, and not be necessarily involved with us, but if they choose to continue to be involved with us, even if their OSI has been treated well, but they want to continue to address other mental health challenges, then,

according to Veterans Affairs Canada, then it's patient choice and we continue care for them.

Q. Are there instances when a patient has been with the clinic for maybe many years and their original diagnosis or ... yeah, their original diagnosis is not responding and various treatments have been tried and are there patients who are in a situation where they're just not getting better?

A. Yes. That's the population we call "refractory" and that's a standard psychiatry term which means that in spite of evidence-based best practice interventions, medications, psychotherapies - even occupational therapy, in our case - they're not responding well, or at least well enough. And we have fairly precise ways to demonstrate how well are they responding.

I don't know if people have talked about outcome measures in this Inquiry, but that is one of our tools to address how well people are doing in an evidenced-based way.

Q. What are some of those outcome measures?

A. So based on a platform called CROMIS - C-R-O-M-I-S - that Veterans Affairs Canada has provided to OSI clinics, we use, currently, four measures, soon some more to be added. One is called the "outcome questionnaire" with the numbers after

that, 45.2. And that's a psychotherapy outcome measure. It has three subdomains in it and it helps learn, including see visually. We graph it on the computer and the client can see that, how their symptom distress, their interpersonal relations distress, and the social role of distress are changing over time. It's a well-evidenced-based measure.

The second would be the PCL-5. It's a post-trauma symptom checklist. It's self-report. All of these measures are self-report by the client. And it shows us the four domains of PTSD - the intrusion, the avoidance, the negative cognition, low mood -and their arousal or activity. And we can see over time how that fluctuates and hopefully reduces over time with care.

The third is PHQ-9 which is a very well-established short depression scale, and the fourth is GAD-7 which is an anxiety scale and, again, very well-established. And we can see fluctuations within and across these measures.

Soon to be added is the DES-2 which is a dissociation scale that I understand is approved by VAC to add to the platform. And we can use additional measures from the clinic that we can purchase and use as needed. But those four I mentioned are those that are routinely employed with a client if they agree. Most clients do consent to do that. And these days, they're

also doing them online, so they don't need to come to the clinic. They get a secure link and they use a password and they respond to the question so that before I meet the client, early in that day, they've done their CROMIS measures and I can actually see, in addition to the conversation with them, how they've been doing.

Q. Thank you. And, finally, you mentioned earlier that the patient is the driver of the care. I understand that to mean the patient must be engaged in the process to be successful. Would you agree with that?

A. For sure, I agree with that, but that's a necessary but not sufficient condition for what we call "person-centered care" or if we just share decision-making. These are standard terms in the clinical literature. And so, for full person-centered care, it's the patient who decides on their care, obviously, with information provided by us, education, if needed, and so on, but, from early on, they set the goals.

If a person with PTSD decides that they do not want to engage in trauma-focussed therapy but they want other psychotherapy, let's say interpersonal therapy, to address their transition to civilian life or interpersonal challenges, so be it. That's their decision. So we educate them about the pros

and cons of that type of decision. That's what the "client driving the care" means in a full person-centered way. And if you look at my *CV*, you'll see that's a big part of my academic work to continue to advance person-centered care, both in Canada and also elsewhere.

Q. And you have to respect a client's decisions, do you not?

A. We have to and by law. So that's, ethically, we have to respect that. Clinically, it's also more effective to have the client drive their care. And, legally, we have to obtain informed, capable, voluntary, informed consent or refusal of care options. We can still recommend and engage in a discussion but, by law, it's the patient who decides, unless they're incapable. And for the clients that the OSI clinic serves, it's extremely unusual to have a client who is incapable to decide on their own care.

Q. Thank you, Doctor. Those are all my questions.

THE COURT: Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Mr. Morehouse?

MR. MOREHOUSE: Yes, I have a few, Your Honour.

THE COURT: Thank you.

CROSS-EXAMINATION BY MR. MOREHOUSE

(12:28)

MR. MOREHOUSE: Good morning, Dr. Rudnick. My name is Thomas Morehouse. Along with my co-counsel, Tom Macdonald, we represent Ricky and Thelma Borden who are the parents and grandparents of Shanna and Aaliyah Desmond. And we also represent Sheldon Borden who is the brother and uncle of Shanna and Aaliyah Desmond.

Now I want to take you back to when you conduct an assessment for treatment or an assessment for disability. It's my understanding that before a psychologist conducts an assessment for treatment they require, at a minimum, written consent to disclose personal health information to the referral source. Is that correct?

A. So, first, my deepest sympathies to the Desmond family.

Q. Thank you.

A. And so the consent, typically, would already be available to us because the referral source who refer the client - and that would be, in this type of situation, Veterans Affairs Canada - would facilitate that. Now if we're missing that, we may miss that, then we would return to the client and obtain a

consent - a written, capable, voluntary, informed consent.

Q. And if consent is not given, you cannot proceed with the assessment, is that right?

(12:30)

A. So that's where it gets a bit complex. So it depends, consent for what? Consent is situation and issue-specific. An example would be, a client would say, I'm willing for Veterans Affairs Canada to see all my disability or treatment assessments but, for the sexual part, be it side effects of medications or sexual history, I don't want VAC to see that. And so there's a process to go through. Usually, it's through the Health Authority. There's a standardized process through health records on how to remove parts of the report so only what the client is willing to message out to Veterans Affairs would be provided.

Q. And I appreciate this would be probably a rare situation, but if a client gave, like, if they refused wholesale consent to disclose anything to the referral source, you could not proceed with the assessment.

A. Well, I would say, we need to help people. So I would say we would engage in a discussion, including the referral source. The referral source has already sent us material, so

they know about the client. And so we'd engage in a discreet, but, and confidential discussion without disclosing what the client doesn't want us to disclose, on the fact that there's a barrier here. We wouldn't just accept things as they are. And if the client insists and doesn't want us to send any reports to Veterans Affairs Canada, then I would ask. Probably the manager, Patrick Daigle, or myself would get involved with VAC and ask, So do you want us to proceed with this assessment, knowing that you would not get a report back? And, based on their decision, we would proceed. And they may decide that they would still want to do that. There's a clear distinction between a disability assessment and a treatment assessment because if the person, the client, has no disability assessment, we don't have the privilege to actually access services through VAC, through VAC's funding. Whereas, if there's already a disability assessment but they just don't want the treatment assessment to go to VAC, that's more grey zone and we would defer to VAC to let us know if they're willing for us to treat without sending them a report.

Q. Okay. And would it be a similar procedure if, let's say at the outset, the client gave consent to disclose personal health information to the referral source, they began a course

of treatment at the OSI clinic, but then partway through the treatment process, they decide, for whatever reason, to revoke that consent? Would it be a similar procedure that you would go through if that was the situation?

A. That is an even more grey zone because we were in the midst of care and funding ... or approval, I should say, for the care has already been provided. And so I would say that we would inform the referral source that we're not sending any more reports based on the client's decision and, unless notified otherwise, we'll continue to provide the care.

Q. Okay. I also understood through your evidence that, you know, a component of the treatment that you provide the OSI clinic involves family members and spouses, potentially?

A. Correct.

Q. And I presume that you would have to obtain a consent to disclose personal health information from the client to disclose to the spouse. Would that be correct?

A. So, yes, but, typically, the spouse has already been informed and, usually, what happens is the client comes with that family member and they discuss that needs together and they inform that clinician of the client. Then it's taken to the IDT team meeting and, from that, we proceed if both the client and

family member are in agreement.

So it would be highly unusual that we had no contact with the family, with member, with the client, when that request is made, but it is possible. So when that happens, then, yes, we would need that consent. Now the different ways of obtaining that consent, it could be on a form, it could be verbal. Typically, we try to put the form, the written, in place too.

Q. Okay. And I want to pose to you the same question I did with respect to the referral source. If you embark on a course of treatment with the client and, at the outset, you had obtained consent to disclose to the party's spouse, and partway through the treatment they decide, for whatever reason, to revoke that consent, what would you do in that situation?

A. Same process. I would inform the referral source that we're not sending further reports based on that family member's decision and, unless notified otherwise, we'll continue with that care because ending care in the middle is unsafe and probably considered by most jurisdictions, unethical and, therefore, we would need a very strong reason why to stop care in midstream.

Q. Thank you, Dr. Rudnick. Those are my questions.

THE COURT: Mr. Rory Rogers?

MR. ROGERS: I'll defer to the end, if I may, Your Honour?

THE COURT: All right. Certainly. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(12:36)

MS. MILLER: Good afternoon, Doctor. My name is Tara Miller. I am counsel representing the late Cpl. Desmond's mother, Brenda Desmond, and, as well, his daughter, Aaliyah Desmond. I share representation with Mr. Morehouse who just asked you some questions. I just have a few questions for you.

You talked about the gathering of collateral information and you indicated that it was not routine during intake to involve family members for collateral information. Is there a reason why that was not routine, or is not routine, during the intake process at OSI to involve family members to gather collateral information?

A. So it is routine to gather it, but not necessarily at the intake stage, because that's the second meeting and the first in-person or online video meeting with the client. And so the triage, the first contact, is fairly short - as I said, about 20 to 30 minutes - and there's already, typically, a

conversation whether the client is comfortable with a family member joining. But, typically, when I say "routine", I mean common. So, typically, clients, when they see ... when they've only talked to a stranger or a nurse once, they may not feel safe enough, but if they're willing to engage their family member in the intake, then they do. It's just that it's not necessarily a common occurrence and we repeatedly ask for that every time we encounter a client.

Q. Okay. So the options are started at triage and then move to intake, but if they haven't been able to give consent or permission to involve a family member, you would continue to follow up through the assessment process?

A. (Nods head "yes".)

Q. You're nodding your head "yes".

A. And later.

Q. And later, yes.

A. Yes. So yes, yes, and later. So including in care, in psychiatric care, psychotherapy, occupational therapy, as relevant, and, typically, I do this regularly. I ask the client, you know, if they're living with somebody, especially like a spouse, are they willing for the spouse to join at least part of one or more meetings. So for the collateral and also

for the psychoeducational part.

Q. So when you do have permission on both sides - firstly, your client, but, I guess, the spouse of the partner to participate - how do you go about accessing that information? Is it a one-on-one with the spouse and somebody at the clinic or does it involve the patient, the spouse, and the clinic?

A. It's usually the patient ... sorry, the family member joining the client, the patient, with that particular clinician, myself, or the psychotherapist, whoever that be, at least for part of the meeting with the client. Sometimes it's the full meeting with the client, depending on the issues.

So if we know there's marital discord, as an example, we could ask the client, we would ask the client, are they willing to invite their spouse for the next meeting to come for a full meeting together ... for us and then to better understand the issues and how we can help with that. And that's not couple counselling, that's a family meeting where we meet together to better understand the issues, not necessarily intervening yet. Unless it's something very pressing, and then we may make a few suggestions in real time, but it's mostly gathering information and educating the couple.

(12:40)

We also invite families to care plan meetings, so those meetings where the client permits us to invite even their case manager from Veterans Affairs, perhaps a community provider, like an OT or psychologist from the community, so that we can share the care planning and not working at cross purposes among the different providers. Family members are invited to that too. Obviously, it's always the client's decision whether to have them join or not.

Q. Okay. So what I'm understanding you to say, Doctor, is that there would never be an opportunity for the clinic to engage solely with the spouse without the client there. Is that fair, that the client is always present?

A. No. There would be an opportunity for that if the client allows that. And some do. Some say, You know what? I know so I want to take a coffee break and just, you know, spend half an hour with my spouse without me. That's fine. But they don't permit us to meet their family member by themselves. We would not unless it's a pressing issue about safety. So we're allowed, like all health care providers, to hear safety concerns of any person, not just family members. A neighbour would be similar, but we can't disclose about the client without the client's permission.

Q. Okay. So assuming you have the client's permission to talk to their spouse or their partner, can you see value in having that conversation with the spouse or partner without the client there, in case there is some reluctance by the spouse or partner to disclose the reality of what's going on behind closed doors at home?

A. Yes, there is value. There's also value in trying to do it together and ensuring safety for that spouse because their rapport, their relationship with the client, is also quite important. And meeting with someone else without their presence, for many clients, is triggering and could disrupt the clinical rapport, which could be counter-productive. And so there are creative ways of making that work but, in some situations, you know, as I said, if we have a safety concern, even if the client doesn't agree for us to meet the family member, we would inform them that, We have a safety concern. We'd like the family member to inform us of what their perspective is and that part of that meeting is best done without the client.

Q. Okay, thank you. I just want to ask you a couple of questions about some of the work you've done that's noted in your *CV*, Dr. Rudnick. There is listed at page 17 of your *CV*,

Exhibit 259, a paper, I think, that you published - peer review publication - called **Burden of Caregivers of Mentally Ill Individuals in Israel - A Family Participatory Study**. Would any of those mentally ill individuals that would've formed part of that study have had operational stress injuries?

A. So these were family members of mentally ill people and, yes, some of the loved ones of those family members would've been military veterans because conscription is mandatory in Israel. So the majority of the population experiences at least mandatory military service of two to three years.

Q. Right. And at a very high level - I mean, certainly, we can get the paper and review - but at a very high level, what were your outcomes and conclusions in terms of the burden on the caregivers of those military veterans by their family?

A. So what emerged from that study, which was done fully in collaboration with the National Family Members Organization of Mentally Ill People in Israel, was that there are practical or instrumental burdens and there are emotional burdens on these families, and even though both were important, what seemed to have been the most, the highest, burden, the most severe burden, was worry. Worrying about their loved ones, and especially

because the majority of the participants were elderly parents of mentally ill people. They were worrying especially about what would happen once they're gone. What would happen with their loved ones who have mental illness once they're deceased and they're not providing their support as parents to their adult children.

Q. Okay, thank you. And my last question, Dr. Rudnick, is in reference to page 33 of your *CV*. This is a paper, it says, "In Preparation Submitted". And it's **Predictors of Outpatient Mental Health Treatment Response of Military Veterans**. Has that paper been published yet?

A. No, it has not. We've presented the findings in academic conferences but we've decided to expand the sample size. We only had 61 participants then because we had fairly rigorous exclusion criteria to make this study constructive. And so we decided to expand it, hopefully getting to at least a hundred participants so we have more statistical power to analyze predictors, especially also to include demographics that we just didn't have enough numbers of, such as women, at that stage. Now we'll probably very soon have enough women as a subsample to analyze for.

Q. For those findings that you were able to make and

present, based on your sample of 61, can you share with us, again, at a high level, what those findings were in terms of predictors about patient mental health treatment response of military veterans?

A. Yes. The most prominent predictor that came out loud and clear statistically was that, even in this fairly small sample, depression is a predictor of negative outcomes. Meaning if a client has depression as a primary disorder, obviously, we'll provide treatment for that, but that predicts that they won't do as well as other clients. And, therefore, we added interpersonal therapy. This was driven by data, the addition of another evidence-based psychotherapy that isn't in the core mandate of Veterans Affairs Canada, but we decided that even though it's not a trauma-focused therapy, based on our data and other reasons, it's valuable to add that to the mix of our toolbox. And we have provided IPT since.

Q. Yes. Okay, thank you. You mentioned that earlier. So that was in response to this significant statistical finding that depression would be a predictor of negative outcomes.

A. Yes.

Q. Okay. Thank you, Doctor. Appreciate your time.

A. Thank you.

THE COURT: Mr. Adam Rodgers?

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(12:47)

Q. Good afternoon, Dr. Rudnick. My name is Adam Rodgers.

A. Hello.

Q. And I represent Cassandra Desmond who is the personal representative of Cpl. Lionel Desmond. I appreciate you taking the time to provide evidence here today. I have some questions for you, Doctor.

I wanted to start with something that stuck out in your *CV* to me. You have a PhD in Philosophy. You've taught medical philosophy, it looks like, at Western and McMaster, and one doesn't have to look too far, just searching the philosophy of medicine online, to find your course that you developed at the University of Tel Aviv. I have a couple of questions flowing from that but I wonder if, first, you might provide us with a brief explanation of what "philosophy of medicine" means or what that might entail.

A. Okay, thank you. So philosophy of medicine - and I'll expand it to philosophy of health, more generally - is an

application of philosophical methods and insights to medical practice, including clinical care, health research, health education, and health administration - the four pillars of health care. And there are lessons to be learned from that. The most well-known application is in bioethics or, more narrowly, medical ethics. And so health care has been revolutionized since the late '70s because of the change in how medical ethics, and health care ethics, more generally, have been put in place, initially in the States and then rapidly expanding across the world.

Therefore, capable voluntary informed consent is a mainstay, it's a necessity, of health care these days. It was not until the early 1980s, which is astounding, but that is the situation across the world. And so that's one clear important application of ethics to health care.

(12:50)

But there are other aspects. So that course I developed at Tel Aviv University is more about philosophy of science applied to medicine, understanding rigorous general methodology. I won't go into the fine technical detail, but the way evidence is developed, including in health care, it's important to think about philosophically because even with our current standards of

randomized control trials in clinical research, which is the gold standard, they're not perfect. And more and more, they methodologically, literature is teasing out now that RCTs are not necessarily the only way to go in a rigorous way. And so philosophy of science can help us understand the basic assumptions of that.

An example would be in NF1 trials. So NF1 trials are studies where the same participant experiences both experimental intervention as well as the control interventions, back and forth. Obviously, you can't do it with surgery - fine - but you ... and not with most psychotherapies, but you can do it with some medications. And so NF1 trials, according to many methodological experts and philosophers of science, is probably even better than randomized controlled trials because the conclusions from RCTs are group conclusions. It's not for that individual. Whereas an NF1 trial, that is randomized. Actually speaks to that individual participant. So it's one level better than an RCT. That's an example of how to apply philosophy of science to health care.

Q. And are there particular schools of philosophy to which you ascribe, or a particular school? And I'm wondering how that might influence the development of the OSI clinic, if

at all? If there's a particular way that you're applying that to the development of the OSI clinic.

A. So from the philosophy of science perspective, I mostly use critical rationalism. It's a minority school of thought in philosophy of science. It's all about no certainty and trying to continue to refute and improve knowledge, knowing that we'll never have certainty.

More practically for the OSI, I use a lot of my ethics background. And, especially, there's a paper I published in 2014 based on work I did in British Columbia and it's about health administration ethics. And what I highlighted there is there are three simple basic principles that should drive all service, delivery, and development, which is being person-centered, and that can be unpacked in many ways. Being evidence-informed. And, on purpose, I say evidence-informed and not evidence-based because we do need to continue to develop evidence. So it's not just what's worked. We need to continue to grow evidence. And then last, but not least, is socially responsible which, again, can be unpacked into fiscal accountability and moral accountability and legal accountability, but those three clusters, based on my philosophical work, really capture much, if not all, of how

health care should be delivered, developed, evaluated, and taught.

Q. Well, it seems to be an emerging field. And, of course, you're identifying that it's in the recent decades. Critical rationalism certainly seems to be the leading philosophical school at this time, so I guess that's encouraging in some ways. I guess I don't want to have too much of a theoretical discussion with you, Doctor, although I would like to, but that's not the most pressing use of our time, perhaps.

I do want to ask you about a few topics that I think relate to that. Maybe I want to start with what health, the term "health" might mean for a soldier coming back from combat with PTSD, perhaps with mild brain injury. You know, that's a different concept than for a person in that circumstance. And I guess maybe you can describe that and then talk about how that is conveyed to the patient.

A. Okay. So, first of all, just a remark about critical rationalism. It is not a majority. It's not popular in philosophy, but it is popular among scientists and has been since it's inception with Karl Popper.

So, going back to health, there is a World Health Organization definition of what "health" is, and I think it is

very user-friendly because it's very ... the WHO has said that for many decades. Health is not just the lack of disease. Health is well-being that's biological, psychological, social, and that also suggests that it could also be spiritual. I would expand it to cultural which is a bit different than social. And the way it applies, in practice, for health care providers like myself; more generally, the clinic, is we do address not just treating symptoms and trying to get people into remission of symptoms, we try to look at their life with them wholistically - W-H-O. Not H-O, holistically, but W-H-O, from the word "whole", "wholistically", so that we're addressing biopsychosocial aspects of their care. And when we cannot provide an intervention in some aspect of that, we would be advocating that someone else be doing that, like, outsourcing that.

It does speak to what I mentioned earlier about biopsychosocial formulations. So we don't just diagnose. When we assess a client, we try to do with them a biopsychosocial formulation which is a better understanding of why they're experiencing what they're experiencing mentally and otherwise these days based on their background, on the environments they live in, sometimes even genetics if there's enough relevant genetic information, their upbringing, their personality makeup.

All of that put together in a standard term called biopsychosocial formulation. And it really helps determine the care provided because the diagnoses are not sufficient to determine mental health care. We need much more than diagnoses to determine the whole package of mental health care.

Q. And is it, in your experience, difficult to explain that to a soldier that's coming back and has, you know, a new life and new limitations, perhaps, and, you know, a new identity, a new health identity?

A. Often, what we find is that veterans, especially if they've been released from the military recently, but even some of those who've been released decades ago are still, in a sense, grieving the loss of their military identity. Not everyone, but many. And so, as part of that, there's a process of coming to terms, including with some health limitations, but not just health limitations. The fact that they may not work again or that they need to find a second ... a new career. And some may come with relevant skills to the civilian life, but some may not. If they work in a very specialized area of the military, especially if it's highly confidential, it may not be translatable to the civilian life and, you know, they may be sitting in college learning a vocation with people who are 20

years younger than they are. And so that's another challenge that many of our clients are trying to come to terms with.

Interestingly, and maybe paradoxically, trying to address the health aspect, the positive health, the well-being, biopsychosocially and maybe culturally and spiritually. It's not difficult with people who have mental health challenges. It's a very common-sense notion that one wants to live with well-being, all aspects of one's life. It's really those transitions, and also those road obstacles, the barriers, such as needing to go to a new career or coming to terms with retirement with severe health challenges, that requires a lot of work.

Q. Thank you, Doctor. Now switching topics slightly, but another question on philosophy of medicine, in a way, and it's to do with privacy. Now normally, Doctor, the public interest in somebody's health information is quite low and, thus, privacy is a paramount consideration. Are there any discussions taking place, or do you consider, that the privacy of a soldier, of a former soldier, may not have that same calculation, that there is a larger public interest and that privacy considerations might be different in those circumstances? And I'm thinking of that in terms of requesting records from other institutions.

For an OSI clinic, perhaps consent is less important. Is that something that you've considered or you have any observations?

(13:00)

A. So, once again, I can distinguish clinical considerations from ethical, from legal considerations. And although they interface and overlap, but they're not the same conceptually and even practically.

From a clinical perspective, to help a person, we need their working relationship. So if we bypass them and inform another institution that they're in our health care, by the fact that we're asking for their documentation, and they disallow that, then, clinically, we're disrupting rapport.

Ethically, as in modern medical ethics, voluntary, capable, informed consent, is a mainstay. We cannot and should not bypass it.

Legally, there are exceptions, but those exceptions typically wouldn't apply to obtaining more information from another institution. They would be more about warning and protecting the public, you know, as is well-known in legal cases across the world, California and so on, and there's precedents in Canada. So we're very limited when a client says, Thou shalt not do this or that with my personal health information, but we

have discussions. And, often, what happens is people, clients, change their minds because now they understand better, after discussion, why it's to their benefit that we obtain more information because we'll provide better and safer care.

Q. Thank you, Doctor, no, that's helpful. And last, I guess, on the topic of the philosophy of medicine, under that general topic, is free will and the competence to refuse treatment. Do you encounter situations, Doctor, with a former combat soldier, somebody who has PTSD, perhaps has suffered concussions and has a brain injury, where the decision to accept treatment is something that may be beyond their capabilities and that they need more guidance or more direction in that regard?

A. Mmm.

Q. One of the considerations, one of the ...

A. So once again ...

Q. I'll tell you the reason I ask, Doctor, is this. And I want to ask you a little bit more about being able to provide services to rural Nova Scotia from the clinic in Dartmouth. In this case, Cpl. Desmond decided and wished to move back home to Guysborough, to rural Nova Scotia, and that presented some challenges in terms of accessing services. Would there ever be a scenario where you would envision somebody being told, Well,

no, you need to live close by this clinic because that's where you can get treated? And you don't know ... this isn't in your best interests to move back there. We're telling you this is where you need to be.

A. So I'll focus on the law. Obviously, there's also ethical and clinical considerations but, here, they overlap very much. Unless the person is formally incapable to make decisions about their own health care - and there's legislation governing that - then they make their decision. There are some discussions for people who are incapable. I have published about that too. So if they're incapable to decide on their own mental health care, are they incapable to decide on their residence? And I've published against that. I have a colleague who has published for that. So that may be a bit of a grey zone. But, unless, legally, it's determined, such as by the attending physician or by guardianship - whichever mechanism it is - that the client is incapable to make a decision on their own mental health care, then their choice determines the care and where they get that.

My experience with the client population we serve at the OSI clinic is that even if sometimes, some clients make poor choices, they're still capable choices, typically. Now there

are conditions, mental health conditions, where the index of suspicion would be higher regarding capacity to make a decision. So, typically, we'll know that would be someone who has a primary psychotic disorder. But, that being said, most people with primary psychotic disorders, such as schizophrenia, are still capable, determined capable, and the law defaults to capacity, the law does not default to incapacity. So the onus of demonstration of incapacity is on the person determining incapacity rather than on the patient. That's my understanding from my work across the country. And so I would say, determining where a client wants to live is up to the client. Now if ... these days, as we're going through a lot of change with remote care, a client living anywhere in Nova Scotia could receive care from our clinic unless they refuse to do that even by phone, because we do provide phone care for people whose internet unfortunately is not reliable.

Now it can't be the full package of care by phone because some psychotherapies cannot be done by phone, but psychiatry management, some occupational therapies, some psychotherapies, can be done by phone.

Q. So your approach would be then, short of incapacity, legal incapacity, that treatment decisions would be discussed.

If you thought the client, the patient, was doing something wrong, not taking good advice or not listening to good advice, you would prefer to discuss that with them rather than impose anything on them.

A. I probably could be legally penalized for imposing anything on clients. It's just illegal.

Q. Yeah. No, that's right. Okay, thank you, Doctor.

In leading the clinical care side of the OSI clinic, are there examples that you've drawn upon, upon which you've drawn, from international, you know, other countries, other clinics, internationally, to establish what you've done here in Halifax?

A. Yes. So both in Canada and outside. Although, in Canada, I didn't focus, until I moved to Nova Scotia, on military veterans. I did treat people with PTSD and other mental health issues, and especially through my leadership experience in British Columbia and Ontario, southern and northern Ontario. That administrative experience and training has helped a lot to try to not just provide good care, but to also continuously improve systems, have mechanisms for that.

So if we can make a difference in people's lives and we're missing on some of that, then we do. That's part of what our quality assessment assurance or quality improvement committee is

doing. So putting those mechanisms in place is something that I've learned across the years in Israel, in Canada. I must say, my military experience in Israel was helpful too. My first term was in the front, but my second term, and then Reserves, was more administrative. And military administration is quite structured. So that always informed my work in Canada on how to structure processes in administration.

Q. I want to talk to you, change topics, Doctor, and talk about providing care to the rural areas of Nova Scotia. And I recognize now that you've talked extensively about the telehealth and the video connections and how that can work, so I won't, I'm not going to revisit those areas, but I want to talk about local health providers. And in different areas outside of the Halifax region, it would be expected, I think, that veterans would be receiving care from local providers. That's fair to say. Correct?

And it seems, in many cases, it is beneficial in some ways, in terms of, specifically with PTSD, I would say, for veterans to be in around nature, in rural areas for other reasons. And they may have social and family connections that they may be benefitting from as well. So providing health care under those circumstances, through local providers, is there anything the

OSI clinic can do to either establish a network - a referral network - or to provide some education opportunities for health care providers around the province that aren't within the OSI structure itself, but would be still providing similar care?

(13:10)

A. So we already do some of that. For local providers, we, even if they're in the Halifax area, HRM, we always invite, if they're involved with our clients, invite collaborative care opportunities and mutual learning. And, in addition, we are opened and available to do education. For example, we provide education to Veterans Affairs Canada case managers. We're always happy for other interested parties to get involved and we're happy to learn from others because the expertise in providing care for OSI is not just at OSI clinics. There's some well-trained and well-practicing community providers who do good psychotherapy. And there's some very specialized resources out there that we don't have. I mentioned the TMS, but there's also specialized psychotherapies that we just don't have and that may be more helpful for clients who I call "refractory". So clients who've gone through the evidence-based approaches, and it's not working well enough, and then they need something very, very specific like brief psychodynamic therapy, possibly. There's a

centre of excellence in Halifax for that. Occasionally, we collaborate with them. So there's all sorts of opportunities like that, we're very willing.

That being said, the main funder, which is Veterans Affairs Canada, has a clear mandate, to my understanding, for OSI clinics which is, primarily, direct care to clients. And there are other deliverables, but they're not the primary deliverable. The primary deliverable is to provide clinical care to clients referred to us by Veterans Affairs Canada and RCMP Health Services.

Q. Okay. So it hasn't been ... you haven't received a directive - I don't mean that in a technical sense - from Veterans Affairs to establish some educational structure for other outside providers around the province?

A. Not to my knowledge. At least not in a very systematic way. That being said, there are collaborative opportunities. The Health Authority in Nova Scotia has a fairly new province-wide educational program for mental health care providers. I think it's primarily for the Health Authority employees and physicians but, that being said, they may be able to expand, and possibly then to join forces with us, specifically for OSI education. We've already been asked,

before the pandemic, to present there on PTSD, pandemic put the hold on that. So there are emerging opportunities but it would be, I think, quite interesting to hear from Veterans Affairs Canada, as the main funder of OSI clinics, what do they think could be the scope beyond the main deliverable.

Research and academic education would be another example. So some of us do research, including, especially, research for OSI clients, but it's not a primary deliverable, to my understanding. And the way I see health care, it's organic, dynamic, and ongoing. And the statistics worldwide, especially from the VA in the US who is the main provider of research for military veterans in the world, is that only roughly 50 - 5-0 - percent of people with military PTSD respond well to all the available evidence-based interventions. Those are the three trauma-focused therapies and antidepressant medications as the mainstay.

So another half of the population we serve, if we look at the American statistics, still need more R and D - research and development - so we can find more solutions to help them.

Q. One of the ...

A. And so I think of R and D as a core part of what a health care system does.

DR. ABRAHAM RUDNICK, Cross-Examination by Mr. Rodgers

Q. One of the key papers that you're working on, and it stuck out to me - you were already asked about this by my learned friend, Ms. Miller, about the predictors of outpatient mental health. And you mentioned, Doctor, that you're looking to add to that research. And I wonder if you can tell us whether part of the addition that you're looking to do, or whether you've already reviewed this, is the African Nova Scotia experience particularized in the military. And, you know, is that something where you've had enough research done to make any observations or any preliminary conclusions? And, just generally, how do you account for the African Nova Scotia experience in OSI therapy or OSI treatment?

A. That's a really important question. We try our best to be culturally sensitive and diverse and inclusive. The research is lagging. There's some from the States, but we need more evidence to see what helps better for some socially-disadvantaged, marginalized, racialized communities. And I would say, also our indigenous communities too. And so we have some clients at the clinic. We are under-represented, to my knowledge, of racialized indigenous clients, and that is an important question. Could we and should we - and I will say yes - have more clients who are African Canadians, indigenous people

who've served in the military. And RCMP. There may be reasons why we are under-represented there, but I'm not sure it's different across other OSI clinics. And it's more work to do.

Q. Thank you, Doctor. Now, just, now, specifically with ... I wanted to ask you a little bit about the treatment of post-traumatic stress disorder with dissociation. And it seems, from what we've heard so far, that there may be difficulties in treating the PTSD with dissociative episodes or dissociative disorder because the exposure therapy that you may want to employ to treat PTSD may, in fact, exacerbate the dissociative symptoms. And so, I guess, how do you approach that dilemma? Or do you see it as a dilemma?

A. It is a challenge. Unfortunately, it's a common challenge. It's a common challenge for people with PTSD, and not just military PTSD. But it's what we would call the bread and butter of psychotherapy for people with PTSD. Often, there will be dissociative symptoms. Sometimes even a dissociative disorder is a comorbidity. And it's part of what the psychotherapy does with the person. If it's not extreme, then it's manageable within their standard psychotherapies, such as trauma-focused therapies, but the extreme forms do require more specialized approaches. Extreme forms would be what I think one

of the previous witnesses called "fugue". So that's ... a fugue is when a person is found in another place. Doesn't remember how they got there. Never leave there for months with a different identity and didn't connect these two persona. Or dissociative identity disorder. What was once called "split personality". That's extreme too. And in Israel, I treated at least one client who became catatonic, as if he had schizophrenia when he was triggered. So he was mute.

So those are extreme forms, but the more moderate, common forms would be depersonalization, when someone doesn't feel the same as they usually do. They may even have an out-of-body experience, derealization, where the environment feels and looks different and, obviously, they can't function well in that type of experience. It could be just dissociative amnesia. They have blocks of their memory deleted that they just cannot access. Could be a few minutes or even a few hours. So a few examples of that. And the psychotherapies would work with them in grounding, helping them remove themselves from that dissociative experience ASAP so that they can go back to functioning through the psychotherapy session, and so on.

Unfortunately, with some clients, it doesn't work and they continue to be triggered with dissociation. And then,

eventually, after we've tried many approaches, the focus of the therapy may shift to less trauma-focussed and other modalities that may still be helpful to them in their lives. Another unfortunate situation is that there are no specific medications for dissociation. Unlike depression and anxiety and even nightmares, for actual dissociation, to this day, there's no evidence-based medication.

(13:20)

Q. Is it necessarily the case that somebody with dissociation is going to be able to experience temporary relief only or is it possible that you can treat somebody with dissociative ... I'm thinking particularly of derealization, which there's some evidence that we may be dealing with here, but is that a temporary relief only or can somebody be cured of dissociative episodes?

A. So I think it's very important, going back a bit to philosophy of psychiatry, that in no psychiatric condition, mental disorder, do you really talk about cure.

Q. Thank you. All right, good.

A. Unlike many other types of health conditions, be it diabetes, be it other ... lung problems, we often talk about remission where there are no symptoms currently added in, but

that means there may be a relapse in the future. And so we both provide care in order to try to achieve remission, but we also provide care to try to achieve relapse prevention so that relapse doesn't occur. But there are situations where, even with the best care and the best coping of the client, relapse will occur. Imagine life circumstances when a loved one dies and it triggers a traumatic memory in spite of being in remission for many years. That's an example where the person may need some more sessions of care or maybe a medication again.

So we're talking about remission, and dissociation would be the same, like, as would be PTSD symptoms in general, and depression and anxiety. We can achieve long-term remission, but there's no guarantee there will not be relapse. That's how we would conceptualize this. And with dissociation, because it's so closely linked to triggering of traumatic experiences, then anything in the environment can trigger dissociation, even if the client has been doing well for long. And some of these, what we call cues, these triggers, may be invisible to anyone else, unnoticeable. But, for that client, because of their particular life experience with those traumas, that may be the cue and then they either have a flashback or they go into dissociative amnesia or they have a panic attack. Whatever the

symptomotology.

Q. Thank you, Doctor. That's very helpful.

I wonder ... I want to ... I don't know how much you know about Cpl. Desmond and his own particular diagnosis, but I wanted to just ... I wanted to see how the OSI clinic now - because we're trying to be forward-thinking here - might treat somebody displaying similar symptoms and have come with similar diagnoses. We know that Cpl. Desmond was treated for five or six years, he was receiving therapies of different kinds. He had been diagnosed with PTSD, depression. He had three concussions that we know about, so probably mild traumatic brain injury, some evidence of dissociation, some suggestion that he may have moral injury, and marital issues.

So, first of all, I guess, where would a condition or a mix like that fall in the levels of complexity that you're accustomed to dealing with at the OSI clinic and how would you approach a situation like that?

THE COURT: Mr. Rodgers, hang on for a sec. Mr. Rogers.

MR. ROGERS: Thank you, Your Honour. I'm just a little concerned with the nature of the question that's being put to Dr. Rudnick. He clearly did not see Cpl. Desmond, hasn't looked at any of the record, and is really being asked for a *post facto*

diagnosis, and I think it's going beyond the scope of what would be fair to be asking this witness about.

THE COURT: Mr. Rodgers, I know you've asked the question, and I would make this observation, that when you're trying to look at what happened in Ste. Anne's and saying, Well, how it might be different in OSI Dartmouth today, I mean, if you look ... you need all the people, all the intake, all what was said, the qualifications of the people that were in Ste. Anne's, in looking and making the decisions and how that would compare to all of the intake and all of the inputs that would come to bear in Dartmouth. And I think it's a question that is beyond what would be fair to put to Dr. Rudnick at this point in time because I don't think it would be particularly productive in providing the Inquiry with information that it might require. So I'm going to ask you to move on.

MR. RODGERS: That's fine, Your Honour.

THE COURT: Thank you.

MR. RODGERS: Dr. Rudnick, I wanted to ... actually, the last topic I wanted to cover was preparing soldiers. And, you know, if you wanted to ... preparing soldiers for battle, preparing soldiers ... you know, somebody like Cpl. Desmond who comes from a place where you don't lock your door and, all of a

sudden, you're gone to a war zone in a country you're not familiar with. How would you ... or do you have any thoughts on how you might prepare a soldier psychologically to deal with that kind of circumstance?

A. So, first, I would caveat this that I'm not an expert in military psychiatry and actual military members, because when I was working at the IDF in Israel, I was a general practitioner. And even after I was trained as a psychiatrist, I worked in medical administration - not in psychiatry - in the military. But I treated veterans there, but I do have the experience across two countries who are quite different in their military because it's mandatory in Israel and it's not in Canada. And so the question could be, How do you prepare a whole population who needs to go to serve in Israel? And the answer is, they're screened. So from early on, at age 16 or 17, when the first contact with the military occurs in Israel, there's an initial screening and anyone who's flagged as possibly having mental health challenges is sent to further assessment. Those who are not flagged and are considered mentally and physically healthy enough to start to serve, are then separated, based on health, into combat and non-combat. I'm talking mostly about men. Now it also applies a bit to

women there. But only to serve in combat, and that would be infantry, artillery, and others - tanks and so on - and special units. They have to have a clean health bill other than very, very minor issues.

So the first step is screening in and out, which is quite important, because that's one of the strongest predictors, not just in the military, in general, that if people come healthier into a difficult situation, then they'll come out, most likely, not too unhealthy. That's one.

Now, that being said, these types of very stressful situations are extremely - could be extremely traumatic. The statistics for many years in Israel, in the IDF, was that the highest rate of suicide in the military there was the first three months because that was considered the most stressful. That's the basic training for combat soldiers.

So we know it's not just combat, but other very stressful physical and social situations, increase the rate of suicide. So the military here and there has the mental health professionals to address that if recognized in real time. So that's the second stage of assessment. To my mind, those services have to be available, including for combat soldiers, so that if anything is flagged, it has to be assessed. It can't

just be left to commanders and peers who do not have the professional skills to assess and help with that.

And the third is, once an issue is identified, it has to be treated early on. There's a very well-known (inaudible) principles from, I think it's from World War 1, where soldiers who had, at some point it was called "shell shock", now we call it PTSD, were treated on the spot in real time, no delay, and they showed, even in World War 1, that they could return then to full functional, many of them, to full functionality and, therefore, prevent what they called a bit later "shell shock".

So we know from the statistics today that soldiers who develop acute stress disorder, which is very similar in presentation to post-traumatic stress disorder - it's just happening now - during or soon after the trauma, up to 50 percent of them will develop PTSD. So early intervention, like in all mental health care these days, is crucial to try to reduce that, what we call "conversion", from ASD to PTSD, to prevent the development of a more persistent disorder like PTSD. So all those services have to be available. I'm not privy to the fine details of the Canadian Armed Forces. I know there are mental health services but, in principle, those three stages are important.

DR. ABRAHAM RUDNICK, Cross-Examination by Mr. Rodgers

(13:30)

And the last, but not least, stage, is once a person is not doing well, even in, with early intervention, ongoing services, including after their release, have to be available, and they are through military clinics and through services like the OSI and community providers. We need better statistics, I would argue, to better know how well are we doing, not just locally and provincially, but nationally, across all OSI clinics and community providers, because a large portion of military veterans receive mental health care by community providers, not by OSI clinics. I would argue strongly, we need statistics for that to know what works, what doesn't work. It's all those levels of the journey of a soldier, and then a veteran, and there are opportunities to do that. Right now, my clinic is doing research, granted research, by the Canadian Institutes of Military and Veteran Health Research, on data of mental health of veterans across the country. And we'll be reporting the results by end of this month to silver and the funder, True Patriot Love. Hopefully, that's one step in the process of having a better understanding of what's happening provincially and nationally so that we can better plan. Health care has to have data that's robust and systematically collected to plan it

well. Otherwise, some of us may be spinning our wheels. Sometimes, we may be providing interventions that may not be the most effective. We may have gaps that we're not identifying.

So I'm sorry if I'm using this opportunity for a call. I don't know if it will translate into something operational, but I do think, like the Americans who have the VA in the US, with robust data, we need a data set that's national so we can use that to improve services.

Q. Thank you, Doctor. And just a final question, and it's a follow-up on what you were just describing. Would you then want to see, as part of a study, or are you doing this as part of your study, some data collection or analysis of early interventions, i.e. post-battle or post-deployment, like, almost immediate interventions?

A. No. Unfortunately, our mandate for this particular study is for veterans, not for members of the Canadian Armed Forces, but I would hope, and I imagine, that this ... there are some data for the Canadian Armed Forces. It's more challenging for veterans because it's a more decentralized system. There's Veterans Affairs, but the providers are OSI clinics and community providers. It's more challenging, but still worthwhile, collecting those data. And, eventually, also fully

interfacing the Canadian Armed Forces with the Veterans Affairs Canada forces. There are projects that have done that which is great. We're uncovering that with our research. But make it a more systematic level.

In any case, for the veterans, I would say we need a more coordinated, or maybe even centralized, database so we can learn from it and continue to improve the services.

Q. Thank you very much, Doctor. It's been very enlightening testimony and I appreciate you giving it. Those are all the questions that I have.

A. Welcome.

Q. Thank you.

THE COURT: Ms. MacGregor?

MS. MACGREGOR: I have no questions. Thank you, Your Honour.

THE COURT: Mr. Rory Rogers?

MR. ROGERS: I have no questions for Dr. Rudnick, Your Honour.

THE COURT: All right, thank you. Mr. Murray, any additional?

MR. MURRAY: No re-direct, Your Honour.

EXAMINATION BY THE COURT

(13:35)

THE COURT: Dr. Rudnick, I just have one question for you, maybe. At one point, we were talking about primary health care providers and that they were added to your kind of clinic team at some point in time. Do you remember when that was? Was that after you arrived there in 2018?

A. So the family physician, part-time, was added to the clinic before my time, in 2017. And the full-time nurse practitioner, myself, and Patrick Daigle, added after we both joined. So that was not too long ago, just a few months ago, to make the primary care provision more available.

Q. So the primary care capability was added in 2017 and that was before you arrived.

A. That's my understanding, yes.

Q. All right.

A. The planning started, to my knowledge, in 2016, but the actual implementation was in 2017.

Q. And we've heard it suggested that a referral to the OSI in Nova Scotia could be delayed or put on hold if an individual did not have a primary health care provider. And this would've been clearly before 2017. Were you aware of any

of those circumstances or a practice of that nature?

A. That doesn't hold for our clinic at this stage. I'm not sure exactly what was the decision-making processes before my time there. I can't speak to that. But since I've come, that would not hold.

Q. No. Well, there'd be no reason for it. Again, if somebody didn't ... if a referral didn't have their own primary care physician, you would provide that presently through the clinic. Is that correct?

A. Correct.

Q. All right. That's good. Dr. Rudnick, I think that's the only question that I had for you, unless Mr. Murray has something by way of clarification. No? After that?

MR. MURRAY: No, Your Honour.

THE COURT: Thank you. We appreciate your time, Doctor. It's been a long morning and I know that you would've taken some time to prepare and review your material before you appeared this morning. Again, we very much appreciate your time. It's very valuable and very important for us to hear what you had to say. So, again, thank you very much. We appreciate your time.

Stay well and have a good day.

A. Thank you so much.

Q. Thank you.

A. Thank you, Your Honour.

THE COURT: Thank you.

WITNESS WITHDREW (13:38 HRS.)

Q. So, you know, in the normal course of events, we would be just coming back from lunch, but I knew it was important to finish with Dr. Rudnick because we had him tied up on the video. And I know we have Mr. Daigle present as well. So we're going to take a break. We are going to have lunch. We'll take a break for approximately an hour and we'll come back at 2:30. All right, thank you.

COURT RECESSED (13:39 HRS.)

COURT RESUMED (14:31 HRS.)

THE COURT: Thank you.

Mr. Russell, I understand that you are going to lead Mr. Daigle through some evidence. Is that correct?

MR. RUSSELL: Yes, Your Honour. He's present.

THE COURT: Okay. Mr. Daigle, would you like to come forward, please?

Good afternoon.

MR. DAIGLE: Good afternoon.

THE COURT: I'll give you an opportunity to determine

who you want to be sworn.

PATRICK DAIGLE, affirmed, testified:

THE COURT: Have a seat, Mr. Daigle, if you'd like. You can remove your mask as well if you're comfortable doing that. The courtroom has been audited for compliance with the Public Health directives in relation to COVID-19, and as long as you are in your seat you can remove your mask if you choose to. If you're more comfortable having it in place you're permitted to do that as well. There's a bottle of water there that's fresh, unopened. That's for you should you choose to have a drink.

A. Thank you, Your Honour.

THE COURT: The documents will be presented. Some documents will be presented to you on the monitor in front of you, and if you need some actual paper copies we can provide those to you as well.

A. Thank you, Your Honour.

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

MR. RUSSELL: Thank you, Your Honour.

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Mr. Daigle.

A. Good afternoon.

Q. Thank you for coming to court and in person in this crazy time.

A. No worries.

Q. So I guess I'll start by asking you your full name for the Court, please.

A. Patrick Martin Daigle.

Q. And where are you from, Mr. Daigle?

A. Originally Enfield, Nova Scotia.

Q. Okay. Have you spent any time in Cape Breton?

A. Just since I took this job on. I built the clinic up here in Sydney.

Q. Okay. I'll ask about that in a little while.

So Mr. Daigle, I'll just again ... the exhibits will come up on the screen. Do you have a preference for a paper copy or a digital copy or ...

A. Digital is fine.

Q. Okay. I guess we'll start by looking and going over a little bit of your *CV*, which is marked as Exhibit 260. You see that in front of you?

A. Yes.

EXHIBIT P-000260 - *CURRICULUM VITAE* OF PATRICK DAIGLE

Q. If at any point you need that zoomed in or scrolled

just let me know and we'll take care of it.

A. Sounds good. Thank you.

Q. So I guess we'll start at page 3 of that exhibit. I'm just going to ask a little bit about your education. So I understand that you are a social worker?

A. Yes.

Q. And when would you have gotten your Bachelor of Social Work?

A. Graduated in 2005.

Q. And where from?

A. Dalhousie University.

Q. And then I understand at some point you went back and got your Masters of Social Work?

A. Yes, I did.

Q. And when was that?

A. I went back in 2007, graduated in 2009 from Dalhousie University.

Q. All right. So I'm going to ask you a little bit about your employment history starting sort of going back and then up to your current position now. I guess naturally the place to start would be ... I guess if we can start at 2005. Just generally what position you held and what were some of your ...

very briefly if you can touch upon what some of your duties were as a social worker.

A. Sure. So my first job after graduating from my Bachelor's program is I held the support service coordinator role at what is legally called the Lesbian Gay Bisexual Youth Project but what goes by the Youth Project in Nova Scotia, and I was there for roughly ... well, from May 2005 till December of 2006 in ... yeah, in the support service coordinator role.

Q. And then it was sort of drawing on your background as a social worker?

A. Yes, it was a social worker position.

Q. So next if we move to 2006 to 2014 - so a number of years there, approximately seven years, I believe - you were a clinical therapist where?

A. So this is at the Mental Health and Addictions Program formerly called Capital Health District's Addictions and Mental Health Program, now Mental Health and Addictions Program. This was out of primarily downtown Halifax location.

Q. So I understand there's no longer any Capital District Health Authority in Nova Scotia?

A. It's now Nova Scotia Health.

Q. Okay. And so what were some of your duties as a

clinical therapist at the time in Mental Health and Addictions?

A. During these years I was ... I delivered a Driving While Impaired program for driving while impaired folks, an education program followed up by assessment to determine whether they had a high, medium, or low harmful involvement with substances, and worked as a therapist treating folks who have substance-related issues.

Q. And so we move to September of 2013 to 2014. It says you were a clinical therapist, but where at this point?

A. This time I had moved over to the Dartmouth office and I took on my first leadership role increasing the services for family members, people who are affected by their loved ones' use in the services of ... in the addictions world.

Q. All right, so sort of a well rounded perspective. You're not only now dealing with clients that are suffering from various psychological traumas or issues, difficulties, and addictions, you're now dealing with the family members?

A. Absolutely, yeah.

Q. And how did you find that, the contrasting roles and how they interconnected?

A. Making sure that we're treating both sides of the equation was important to me. It was going before I took this

role as well. Probably one of the reasons I ... the role was created. So it was a good balance to be able to see not only the person struggling with a substance abuse, which I still had a caseload of, but also their family members for psychoeducation and support.

Q. And I guess someone's recovery or treatment, as a rule, extends out just beyond them and extends to their social network which includes their family?

A. I'm a firm believer that if someone is struggling with substances that you cannot simply treat the individual struggling because there is anywhere from eight to nine people who are also impacted by that. So if we're teaching communication skills and setting boundaries and self-care to the client we also have to teach that to the people they're going home to and communicating with and setting boundaries with who are also becoming, in some cases, as unwell as they are. Unwell as they are without even using substances.

Q. So does the same sort of principles apply to someone that is suffering from military trauma or operational stress injuries as it relates to their employment, whether it's RCMP or military?

A. It does extend beyond addictions, solely addictions,

mental health as an operational stress injury would be when people ... which I term affected others. So they would have affected others as well.

Q. And, in turn, does that sort of impact them in their abilities to navigate through the difficulties that they're experiencing?

A. Absolutely.

Q. So if we turn to ... which is page 1. October 14th, 2018, then you had done four years. What was your position for those four years?

(14:40)

A. So I was the clinical team lead for Central Zone Addictions program. So the addictions portion of Mental Health and Addictions. So I provided the clinical support to the team members moreso. I still carried a small care load of people, of clients themselves, family and people struggling. And facilitated groups. But I also supported the clinicians at this point in providing treatment.

Q. And now we turn to the role that sort of brought you here today, which is ... you were in this position from February 2018 to present. So what is your position and where is it at?

A. So I'm now the provincial manager ... Health Services

manager for the Nova Scotia Operational Stress Injury Clinic. My primary location is in Dartmouth, Nova Scotia.

Q. So how did ... how do you see that your past experience and past employment history has affected and influenced your ability to sort of operate in this position?

A. So the number of leadership opportunities that I've had over my career within Mental Health and Addictions, it was something that I wanted to pursue. I wanted to increase my skills into a more managerial position, and I also wanted to stay within the Mental Health and Addictions world. So when this opportunity came up it was a good fit.

Q. And I understand from the evidence earlier today that the Operational Stress Injury Clinic is in Halifax? Or ...

A. Dartmouth.

Q. Dartmouth? Yes. And I understand that it might have began operations in late 2016?

A. From my recollection, it opened up in October of 2015 and they started seeing clients in February of 2016.

Q. Okay.

A. And I think it was in a previous location for a period of time.

Q. Okay. So I guess we've heard the phrase a co-

leadership model, which involves Dr. Rudnick and yourself. How does your role sort of intersect with Dr. Rudnick? What's your aspect of the co-leadership model, I guess?

A. For sure. So we collaborate a lot, but he is the clinical director. So he heads clinical ... the main ... if we think of umbrella, the main clinical issues, and I am operational.

Q. And so your role from the operational side of things. Generally, if you could tell us ... and we can get into some details as we go along. But generally, what is your role and duties in the operational side of things?

A. So for example, I would manage the budget of the OSI clinic. I ensure that we are meeting the provincial health authority's regulations. I do the hiring of the clinic. But, again, with consultation, because there is a grey area in a co-leadership model. And I deal with, you know, the pays of the team members. Like anything that falls under operational. The building, the maintenance, all of those kind of different reporting systems.

Q. So just so I could get the timeline, I guess, tidied up a bit. So to your knowledge, has the operational stress clinic always had this co-leadership model between clinical side

of things and the administrative side?

A. No. The co-leadership model was officially brought to the clinic when Dr. Rudnick started and that was in October of 2018. He is the first clinical director of the clinic.

Q. So I guess if you could tell us a little bit about the rationale behind the co-leadership model and why it ... I mean clearly you have it. I'm assuming it has its benefits.

A. Absolutely.

Q. And so what are the advantages of having that model at the OSI clinic?

A. Well, from my career, there's usually been a co-leadership model. Mental Health and Addictions has been under a co-leadership model for a number of years. Dr. Rudnick was hired prior to my arrival at the clinic, and I ... so I see the ben- ... even though I come from a clinical lens, I don't come from a clinical medical lens, and it's important to have that medical leadership and also, as an operational manager, I can't do both sides of that. I don't have the experience, the knowledge. So we need to have that collaboration back and forth, and a lot of managers aren't clinical at all. So to have that clinical lens, I find, is invaluable.

Q. And so if we could just talk a little bit about the

structure. So am I correct in saying the Operational Stress Injury Clinic operates under the umbrella of Nova Scotia Health Authority?

A. Yes. We are a federally-funded program, 100 percent funded from Veterans Affairs Canada, and through a memorandum of understanding, we're provincially housed in Nova Scotia Health.

Q. Okay. And so the OSI clinic in Nova Scotia, in the aspect of funding, where does the funding come from? I know we learned a little bit that it also involves RCMP members but where does the funding come from?

A. Veterans Affairs Canada.

Q. Even for the RCMP members as well?

A. So if RCMP members ... it's all funded through ... through Veterans Affairs Canada. We would bill Blue Cross for active RCMP members.

Q. Okay.

A. Yeah.

Q. In terms of the structure before we get into the clinic a little bit more. The structure of the Nova Scotia Health Authority, is it broken up into ... as it relates to Mental Health and Addictions, is it broken up into zones within the province?

A. So the province is broken up into zones.

Q. Yes.

A. But we are provincial. So we cover all those zones.

Q. Yes, so could you tell me. There are four zones, I believe, in Nova Scotia?

A. Yes.

Q. Mental Health and Addictions under Nova Scotia Health Authority.

A. Nova Scotia Health Authority is broken up into four zones which ...

Q. Yes.

A. ... Mental Health and Addictions falls within.

Q. Okay, and which district does Mental Health and Addictions fall in? Just ...

A. All four.

Q. All four. Okay.

A. All four.

Q. And so the clinic itself falls into what zone?

A. So the Dartmouth clinic falls into Central Zone and the Cape Breton satellite site falls into Eastern Zone.

Q. All right, and everyone, I guess, has got a boss. I'm assuming.

A. Yes.

Q. Unless you're the queen. So where does ... does each zone have a director?

A. So the director of the provincial OSI clinic is Rachel Boehm, who is the Mental Health and Addictions director of Central Zone.

Q. Okay, and who are the other directors of the other zones?

A. That's a good question. I mainly deal ... my manager of the provincial clinic is Rachel Boehm.

Q. Okay, and she would report, ultimately, to whom?

A. Sam Hodder.

Q. Okay, so she is the director for the province of Mental Health and Addictions.

A. Yes.

Q. Okay. So given that structure, the operations of the clinic itself that fall within that Central Zone, do you ever sort of collaborate with the directors of Nova Scotia Mental Health and Addictions?

A. I collaborate with Rachel and I collaborate with Sam Hodder on some issues as well.

Q. Okay. So while, I guess, funding is from a Federal

entity, Veterans Affairs Canada, the operations itself are provincial.

A. Yes.

Q. So I'm going to ask you a little bit about ... if we turn to again page 1 of your *CV*. I'll just wait for it to come up on the screen there. The second paragraph under your current position. The first line reads:

> The Health Services manager (which is you) is responsible for the immediate day-to-day supervision and management of all aspects of specific clinical program components in keeping with both the requirements of NSHA (which is Nova Scotia Health Authority) and VAC (Veterans Affairs Canada) guidelines for OSI clinics.

So tell me a little bit about what you mean there by requirements of two entities that you're complying with.

A. So we have a mandate within the Nova Scotia Health Authority to serve the client communities under the Mental Health and Addictions Program. So we are operationally run, which means that we have to comply with the provincial guidelines, the same as Mental Health and Addictions broadly

would do.

Nationally, what that means is that we serve the client populations that are referred to us by Veterans Affairs Canada, the RCMP, and to some extent the Canadian Armed Forces, under the regulations that is set out federally. So being those populations and through those specific referral sources.

Q. Do these guidelines ever ... in your experience, have they ever conflicted with each other?

A. That was an interview question.

THE COURT: You must have gotten it right because you got hired.

A. Well, I can tell you what I said.

THE COURT: Start. Go ahead.

(14:50)

A. I'm trying to think of an example where they might have conflicted with each other. I mean maybe the best ... just as an example, I think the best thing is my answer to ... when I asked in my interview, which is we are all trying to maintain a certain goal for the client communities we serve, and if it ever did conflict I have relationships on both sides where I think I could bring everybody together to at least talk it out to find a common goal.

MR. RUSSELL: Okay. So I guess there is potential, I guess, that the guidelines may conflict in some scenario, but in terms of an exact example, you're not aware of one right now.

A. Not in this moment.

Q. Okay. So the second aspect that I wanted to ask you about a little bit is ... again in the same paragraph. Just bring it back up. Below it you said:

> This includes developing and maintaining critical-to-client outcome clinical service delivery-level relationships with other components of mental health and addictions.

What do you mean by that?

A. So a big part of the OSI clinic is that we do really rely on outcome measures. So like Dr. Rudnick was talking about, we have measures in place to show the outcomes of the client we're serving. So over time we can see through our CROMIS program if a client ... if what we are doing is being effective, and that gets reported up nationally.

Q. So is it part of sort of the ... and Dr. Rudnick talked a little bit about the CROMIS evaluation that sort of follows a client through their time at the OSI clinic. Does that apply to basically every client that goes through the OSI

clinic? They're administered the CROMIS tools to gauge sort of success?

A. Yes. CROMIS is best ... the best outcomes is every time a client arrives at the client, if in person we administer an iPad to them where they fill out these tools, if it's virtual we gain the consent to send email and they fill it out email. Now they can refuse, and that is within their right. But we do have conversations with them to talk about the benefits of the outcome measures. And last I checked, we're about at an 83 percent compliance for having the CROMIS data.

Q. So what's the advantage, I guess, to someone that is a client that is being treated for an operational stress injury, I'm going to say in-house in the sense that they're affiliated with the OSI clinic, as opposed to accessing parts of a care model in the basic, general resources within the province? What's the advantage of having this CROMIS tool used at the OSI clinic as opposed to not having it used outside?

A. Well, outcome measures at the very heart tell us if what we're doing is working. I think that that ... that is the main goal of it, and so a client can also see their progress. Because sometimes it can be hard for a client to see if something is working or not over a short term.

Q. And so would you say that the CROMIS tool that's very sort of critical to maybe what makes the OSI clinic a little different than healthcare that could be accessed in the community is that you're monitoring success rates and how you're doing when you're affiliated with the OSI clinic?

A. That is a variable, yes.

Q. So a little bit about the clinic itself since your involvement in 2018. Has it expanded?

A. From an HR perspective, yes.

Q. And what do you mean "from an HR perspective"?

A. So I have added other positions and other disciplines to the team since I arrived.

(15:00)

Q. What about sort of ... we heard Dr. Rudnick talk about the different social workers, psychologist, psychiatrist, nurses, a nurse practitioner. Have those ... outside of ... we'll put aside the satellite office. But the clinic itself within Dartmouth, has the staff increased in terms of mental health professionals?

A. Yes.

Q. And if you can tell us a little bit about how that's expanded.

A. So when I first took the clinic on I believe there was ... there was a greater number of psychologists on the team, which I still may add back in, but I decreased them because we had some turnover. So I wanted to get a firm foundation of psychologists on the team, and at the same time I decided to increase social workers. Social workers can do the psychotherapies, but we need psychologists to do psychotherapies and psychological testing.

So I increased the social workers on the team to ... now we have, in Central Zone, four and we have two more in Cape Breton. And they're all full-time. And now we have three psychologists. I am planning to add another psychologist in the new budget year, which is coming up very shortly.

And in this past year - so this past fall - we added a nurse practitioner to the team. So the nurse practitioner, whose role is to see psychiatric and medical clients for continuing care and then that would relieve some of the pressure to see more assessments from our general practitioner and our psychiatrists for less complex clients. So they would move over to the nurse practitioner and then they could move back if needed. So working as a team back and forth, internal referrals.

There was an occupational therapist already on the team when I arrived, and in January of this year I increased that to a second occupational therapist. So she started at the clinic, and they are two now permanent positions.

Who am I missing here? We had two nurses when I arrived at the clinic. I've increased by one. So we now have three nurses at the clinic.

Q. So it seems like there was quite sort of an expansion of expertise from all different fields: psychologists, social work, nursing. Was the expansion due to ... has there been sort of an increased need or access to those OSI services?

A. Well, I'm also strengthening the ability of an inter-disciplinary team to deal with some of the ... or to serve, I should say, some of the client needs that are coming up. So with our clients we see the need for more need for an occupational therapist, you know? When that ... when that got ... when a waitlist started I was like, Okay, this isn't going anywhere, we need to add this.

And also the clients' numbers went up as well. So we needed increased clinicians because we've almost doubled the number of clients within the clinic itself.

Q. Okay. Do you have a ... I know numbers can sort of be

tricky. Do you have an idea of the number of referrals you would receive from the Veterans Affairs and RCMP within any given year?

A. Oh, a year.

Q. Or month to month or week to week.

A. It ebbs and flows to tell you the truth. Certainly in the last year with the pandemic we ... as everyone learned to do things from home. So there was a number of months where they went down. I know we report early pandemic in our article. Certainly by June the numbers started to increase. I would say we get, you know, three to five a week but sometimes it might be lower. Sometimes it might be higher.

Q. So you mentioned two things there previously that I'm curious about. One, you indicated the importance of a psychologist in a number of respects. You indicated one was that they can administer testing.

A. Yes.

Q. That perhaps ... my understanding of a psychologist, they could administer a different diagnostic testing, I guess, if that's even the right phrase, whereas a therapist, a registered therapist or even a social worker or a nurse practitioner wouldn't be able to administer. Is that correct?

A. Yes, psychologists can do psychological testing.

Q. Okay. Why is it important for ... and I know it depends on the military veteran, what they're suffering from. But well, let's take a veteran that's suffering from PTSD, major depression, mixed personality traits, substance abuse in remission, and family life stressors. Why is it important to sort of have a psychologist maybe administer certain tests?

A. It's a bit outside my scope to answer that.

Q. Okay. Sure.

A. I can ...

Q. That's fine.

A. I would be more comfortable, you know, if you had said, for example, personality disorders. There is psychological tests we do for personality disorders, not necessarily if they just came with some of the things that you you've listed.

Q. Okay. In terms of ... we heard Dr. Rudnick talk about ... I don't know whether it was a policy that's ... and maybe you would know if it's a policy, at the clinic where it's preferred that a psychologist have or a therapist be trained in two of the goal standards, I guess. You referred to a prolonged exposure therapy. What were the other two?

A. Cognitive processing therapy and EMDR.

Q. Yes. So is that a policy from within the clinic itself?

A. It's not a written policy but it is something that I do do. So when someone starts at the clinic, if they do not have one of those trainings, the thing about the Operational Stress Injury Clinic is that we make sure they do get those trainings.

Q. And why is it important to make sure that your staff that are ultimately going to see the patients are trained in those gold standards and have competency in those?

A. So we want to make sure that we're providing the evidence-based care to the client communities we're serving.

Q. Okay, and so we've talked ... and we'll talk a little bit about sort of rural healthcare and how you draw from outside resources as well to assist in times of where you have to provide care in a rural setting for whatever reason. Are you actively ... do you actively keep sort of a roster of potential psychologists, therapists, or social workers? For example, you have a client that's in Port Hawkesbury, doesn't want to travel to Halifax, but you know they need treatment and they need treatment for PTSD, depression, substance abuse. They have some

mixed personality traits, a conglomerate of issues.

Do you have a roster of psychologists that you can try to draw from when you're accessing those outside resources?

A. So no, we would not make specific recommendations as a public system to a specific private individual. We would make those treatment recommendations and then we would make those recommendations to the Veterans Affairs case manager or the RCMP and also say, And this client could access services in these ways at the OSI clinic.

Q. So basically, so the clinic would then say to Veterans Affairs in that scenario, say, Your client is wishing to receive treatment in the community, here's what we see based on the information we were given, here's what we see that they need, and we recommend you get a therapist, psychologist, or social worker that has this level of competency.

A. Yes.

Q. Was that policy always the case or was it always in existence since you became involved?

A. It's been in existence since I became involved, and it was in existence in my past world of mental health and addictions generally as well. I don't know ... I can't speak to the OSI clinic before I got there.

Q. Okay. I guess it's ... my question sort of is ... and I realize you can't speak to Lionel Desmond's circumstances but I'm trying to draw from the way that the system currently operates.

A. Sure.

Q. Is Nova Scotia OSI we know can only receive referrals directly from Veterans Affairs or through the RCMP.

A. Yes.

Q. And you were going to say something there. I think you were going to correct me a little bit. Go ahead.

A. No, just ... and also Health Services of the Canadian Armed Forces.

Q. Okay, and Health Services from the Canadian Armed Forces. So have you seen where an OSI clinic in New Brunswick sent you the paperwork directly, maybe, as well as Veterans Affairs, that OSI New Brunswick tried to send a referral directly to Nova Scotia. Have you seen an example of that?

A. I have not personally seen an example of that and ... but however, I could ... I theoretically could see it happening and we would make sure that Nova Scotia's Veterans Affairs was also part of that process.

Q. Okay. Because I understand Veterans Affairs Canada

has the final stamp of, Yes, we're referring, or, No, we're not.

A. Yes.

Q. It doesn't rest with you. It doesn't rest with the other clinic?

A. No, it's Veterans Affairs Canada.

Q. They're the ones with the say.

A. Yes.

Q. So we'll go through the referral process. So you get a referral at the OSI Nova Scotia from Veterans Affairs. Included with that is the paperwork from the client's experience at the OSI in New Brunswick. In the report the psychologist says they need this and they need this. What conversation happens between Veterans Affairs and who at the clinic, I guess?

A. So Veterans Affairs would send ... we have a referral process that we've developed to support Veterans Affairs of things that would be helpful for us to receive when sending over a full referral. And we work with what we kind of get and then our nurses would review that information. They would make a triage call to the client. Nationally, that is within the first 15 days is kind of the guideline.

Q. Mm-hmm.

A. I checked our last quarter. We were doing it on

average within five and six days. And that call is to confirm whether the client would still like treatment, to engage demographics. And also this is nationally what is termed the first meaningful clinical contact, which means we're also doing a brief risk assessment with the client.

They would continue to ... the nurses would continue to review that information and they would go to multiple sources, whether it be private practitioners, you know, to try and get information that may be missing in preparation for an intake and then an assessment. The client, during the triage call, is booked in to an intake meeting or session.

If the nurse has questions ... it's a complex case, it is a ... somebody we have a ton of information for, maybe he doesn't ... we don't want to put the client through talking all that stuff out, you know, from a trauma-informed lens. We want to reduce the amount of times clients are talking about different things. It's taken to our weekly intake meeting and then they ask the questions there, and we as a team, we flush out, say, Okay, no, we really think we should do that intake, or, It would be helpful to go get this information, something that may not be on the referral sheet but we would find helpful and can we get that.

And the intake team is myself, Dr. Rudnick as our clinical director. Our new clinical team lead is present, as well as ... and she is a social worker. So she's also representing the social worker discipline. We also recently added representation from psychology and occupational therapy to that team, as well as our two nurses.

Q. And this is at the triage phase.

A. This is between the triage and the intake phase.

Q. So I guess I'm trying to get the sequence down in terms of ... the referral comes in. Do you need the green light as to, Yes, as Veterans Affairs, we approve the referral before you reach out to the client?

A. So that would come with the referral.

Q. So right now ... so now right on the referral is sort of the approval.

A. Yeah, so with the referral ... so we call the referral ... what we've supplied Veterans Affairs Canada is a referral fax coversheet which has tick-boxes of different things. With that is a Veterans Affairs form they send back with ... and on that form it says, This person needs a disability assessment, this person needs a treatment assessment, or, This person needs a disability and treatment assessment. And those check-boxes is

what gives us the access to follow through with whatever assessment they're looking for.

Q. Currently, and in your experience, do you often see ... or how frequently do you see a Veterans Affairs case manager, perhaps, say to the nurse at the clinic, I spoke to the client, put the referral on hold, he'd rather access resources in the community? Did you encounter that frequently?

A. Not frequently but it has happened.

Q. And in a scenario where it has happened is there any sort of conversation that takes place? Because you had indicated earlier, you said that it was important for the clinic to relay to Veterans Affairs that they get the proper treatment which comes with core competencies, I guess, gold standard in certain therapies.

When that scenario happened, when you're there as the administrator, was there a discussion between the clinic and Veterans Affairs?

A. Well, we don't know all the variables that are going on, nor would they ... do we need to know all those variables. But also, there ... we are not the only game in town. So there are ... whether it be private practitioners or of other places, whether it even be the public system, that are trained to do

some of these different protocols, and if the client chooses to go to one of those then that would the client's choice.

Q. And I totally understand that, but is there any sort of system or mechanism in place where you're notified Veterans Affairs has spoke to the client, not interested, just wants to access a therapist in the community, thank you very much? Is there any conversation that takes place? Because at that point you have the referral documents. You have the history or ... to some extent, which has been reviewed, and you see a client that's in need of certain care.

(15:10)

A. Mm-hmm.

Q. Whether it's recommendations that are made or identifiable issues that come from your team. Do you ever relay that back to Veterans Affairs and say, Just by the way, if they're looking for a therapist in the community your client needs X, Y, and Z?

A. So I think we jumped a few steps.

Q. Sure.

A. Because ... so we're at the triage call.

Q. Yes.

A. So there's no recommendations yet. There's no

assessment done yet. It would be different at the stage I think you're maybe referring to is after the psychiatric assessment by ... or the psychological assessment by a psychologist or a psychiatrist. Then we provide a treatment recommendations in that stage. Maybe there would be more of a conversation with Veterans Affairs, but also, most likely in those assessments it says "or by client choice".

Q. Okay. So even before you get to an assessment. You get the paperwork last week. This week Veterans Affairs case manager tells you, Spoke to the client, client is just interested in accessing services in Yarmouth. But in your package you have a history there that's been reviewed by a nurse. Is there any conversation with Veterans Affairs at that point to say, Oh, by the way, if you're looking elsewhere you might want to look to see if he gets these certain things?

A. I guess it would depend on what information would be in that assessment because we don't know ... we haven't done the assessment yet. We're just reviewing information.

Q. Okay. I'll give you an example. So the veteran has been treated at an OSI clinic in New Brunswick. In that chart he's diagnosed with PTSD. He's diagnosed with major depressive disorder. He hasn't been responding well or compliant with

medications. He has a number of significant life stressors. He's moving back and forth between provinces. You have that information. That's charted documents from New Brunswick OSI that came to you from Veterans Affairs. The nurse has reviewed that. Veterans Affairs decides to call it off.

Is there any conversation that ever takes place between your clinic and Veterans Affairs where you alert Veterans Affairs and say, Look, it's come to our attention, our professionals have looked at this, you might want to keep this in mind when you're looking for resources in the community. Is there any sort of assistance going back the other way?

A. There is no ... I guess ... I don't evaluate that. So I'm not sure. That's not standard policy.

Q. Okay.

A. So if a client is making a decision, then we're respecting the client, but if Veterans Affairs, who is the funder, is making a decision, then we trust that that ... something is in place for that individual.

Q. Do you have much experience and knowledge of Veterans Affairs case managers, whether or not they have a mental health background or training, whether or not they're social workers, psychologists, nurse practitioners, someone that can appreciate

the data and information they're looking at?

A. My understanding is that they come from a variety of backgrounds. I'm not sure which ones are which.

Q. Okay. When the clinic first opened we heard information that there was a psychiatrist that was only employed part-time and was maybe there five days a week at the ... not quite five days a week. What is the status of psychiatry services now at the OSI clinic in 2021?

A. So Dr. Rudnick is a full-time psychiatrist but also clinical director. So he is clinical director .33, psych- ... or clinical point .33, and research .33. And then Dr. Pamela Arenella has joined the clinic and she is a .6 clinical, a .6 academic teaching and then ... no, .6, .2 academic teaching and then .2 working for Community Mental Health and Addictions doing complex addictions assessments.

Q. So that was a lot of points. So ... but in simple, straightforward terms, I think of a full-time psychiatrist, somebody that is there. She's there seven days a week, always on call. How many equivalents of that do you have?

A. So she's there five days a week.

Q. Okay.

A. So maybe the definition of "clinical" is the most

helpful.

Q. Okay.

A. So she is a .6 clinical.

Q. Yeah.

A. So three days a week.

Q. Three days a week.

A. Yes.

Q. And so as a rule, do you have a psychiatrist on duty the five working days of the week in the OSI clinic?

A. Yes. Yes, and we also have a nurse practitioner who can also cover when they're not there.

Q. What about sort of evening hours? So Monday to Friday after hours is there a psychiatrist available at the clinic?

A. So our clinic is from 8 until 4:30.

Q. Okay. Okay. After hours if a military veteran needs to access psychiatric services where do they go? And they're affiliated with the OSI clinic. Where do they go?

A. Right, so we are not an urgent service. So that is where the provincial Mental Health Mobile Crisis Team or Mobile ... or in different parts of the province just the Mobile ... sorry. I'll get rid of the word "mobile". Provincial Crisis Team or emergency rooms.

Q. And does the same thing apply for weekends and holidays?

A. Yes.

Q. Could you tell us a little bit about the ... I was going to call it a mobile crisis team but ...

A. They've changed recently.

Q. And so what's the new phrase?

A. Provincial Mental Health Crisis Team.

Q. What is the Provincial Mental Health Crisis Team? And I ... so before I ask that, is that a part of the OSI clinic?

A. It is not, no.

Q. That's something that's available outside the clinic.

A. That is for the Province of Nova Scotia.

Q. Could you tell us a little bit about what that is?

A. So that is a team of individuals who operate out of Nova Scotia Health. They are mental health professionals: nursing, social work, and maybe other. They work with the police collaboratively and they support people in crisis with mental health issues throughout the Province of Nova Scotia.

Q. So military veterans that are affiliated with the OSI clinic in Nova Scotia, are they told about that service?

A. Yes, they are.

Q. And how are they told about that service?

A. That would be something that is on ... a couple of things. So that is mentioned during their triage call. It is ... and we also send out a welcome package to the client. So it is in the welcome package letter. We send out a letter reminding clients of, for example, when an assessment is booked. It is in that letter and it's also in the closure letter to the clinic as well.

Q. And I understand there's real value in, one, having that service, but two, veterans being aware of the existence of it.

A. Yes.

Q. Why is it important for the veteran to be aware that there is a crisis team available to you after hours, on weekends, and during holidays?

A. You're right, so ...

Q. Why is that important for a veteran that's affiliated with the OSI clinic to also be aware of that?

A. It's important for anyone in the province, including military veterans, to be aware of that. Because anyone can struggle with mental health.

Q. And in times of crisis they know where to look.

A. Absolutely.

Q. And there's a real value in that.

A. Yes.

Q. Do you know if ... it's an unfair question. Is there anything offered in ... to alert, maybe, members that aren't affiliated with the OSI clinic in Nova Scotia about the existence of this program?

A. I'm not sure.

Q. Okay.

A. Yeah.

Q. Are they ... just every veteran that comes to Nova Scotia, to your knowledge, does Nova Scotia Health Authority give them that care package that a veteran would receive if they were affiliated with the client? When I say care package I mean giving them the information about the crisis after-hours team.

A. What part of Nova Scotia Health are you referring to?

Q. Just Nova Scotia Health Authority for example.

A. I mean, you know, certainly if they look at the Nova Scotia Health website it's very clear on there. There's different avenues. You see it in Nova Scotia. It's becoming more plain language. I can't speak to what packages or whatever might be there, including the military, when discharging.

Q. Okay. That's fair.

A. That might be another option as well.

Q. All right. If we turn to Exhibit 261, page 7. These are materials that were provided by you through your counsel. It says "Resources - VAC assistance service offers 24-hour counselling with mental health professionals". What is that?

A. So the Veterans Affairs assistance line is through Veterans Affairs Canada. So this is a service also for military veterans where they can call 24 hours a day, seven days a week and get service in the moment there as well.

Q. And veterans affiliated with your clinic are reminded of the existence of that program?

A. Yes. In the welcome package that we send out, the pamphlet goes with it as well.

Q. Okay. And below that it says the operational stress injury social support, the OSISS.

(15:20)

A. Yes.

Q. One, what is that?

A. So OSISS is a program within the transition unit of the military housed out of Windsor Park in Halifax and then they take care of provincial and I think parts of PEI. And they are

first voice, family and veterans, who are also federal employees, or they are now federal employees as part of this program, and they provide peer support to veterans in Nova Scotia.

Q. And in your experience why is this program of peer support of people that have had shared experiences, why is that valuable to a veteran who is struggling with mental health?

A. Peer support is extremely important because it provides an opportunity for someone who has lived experience to connect and to be able to understand what the individual might be going through on a peer-to-peer basis.

Q. Okay. And that's in the welcome package as well?

A. Yes, this is part of the pamphlet.

Q. Next, "OSI Connect". What is that?

A. OSI Connect is an app that has all of the contact information for the OSI clinics across the country. It has some self-care tips and different ways that can benefit the client should they wish to.

Q. Part of the OSI welcome package?

A. Yeah, this is all in the pamphlet that goes in the welcome package.

Q. Okay. And then it says "Emergencies". It talks about

in a moment of crisis here's another ... and it references the Mobile Crisis Team.

A. Yes.

Q. So that one ... we spoke to that earlier.

A. Yes.

Q. So I guess if a veteran never gets affiliated with your OSI clinic, to your knowledge, do you know they get ... do they get the welcome package?

A. They wouldn't get our welcome package, no.

Q. No? Do you know if they get one from anywhere else?

A. When you're discharging from the military there is a conference called Simber ... not Simber, sorry. SCAN conference. I don't know what it stands for. But during that it's two or three days of intensive what are all the resources available to you in the community. So for example, we're there. We make a presentation. We have an information table.

Q. Mm-hmm.

A. And they all have information as well and then the Military Resource Family Centre would be something, as well, that provincially people can connect to. But I have to say I'm not an expert on all of these supports and services within the military.

Q. Sure. But do you see some value in sort of reminding the veteran about these resources when they're affiliated with your clinic?

A. Again, not knowing all the ways that might be happening if they're not affiliated with our clinic, I do see a benefit to it, yes.

Q. Okay. I'm going to ask you a little bit about referral forms that you spoke of earlier. Page 29 of the same exhibit, which was Exhibit 261. So I guess this referral form, is this the referral form you were speaking of earlier that comes from you to Veterans Affairs?

A. This is a referral form that we created for them to help support them in collecting helpful information when making a referral to the client.

Q. Do you know when this form was created?

A. This is an updated version of this form. This version of it is probably eight to nine months old. I mean it hasn't changed a big lot, but I mean the form itself predates my time at the clinic.

Q. Okay. Do you know if this form existed back at sort of the foundation of the clinic?

A. I'm not sure.

Q. Okay, and the reason why I ask is we hadn't seen any sort of form like this in this detail coming from Veterans Affairs to OSI Nova Scotia.

A. For sure.

Q. So on this form, directly written on the form, it says, "Please complete sections below." Do you see that in the bold?

A. Yes.

Q. And I'm going to read it. It says:

> Supporting documentation is requested with referrals to ensure continuity of client care, minimize duplication of services, and to work collaboratively with our community partners.

A. Yes.

Q. I guess why is that important and then why is it important to have that right on the form for Veterans Affairs to see?

A. So we don't want to be ... for example, if we are requesting ... if we already have a request out for a private practitioner's notes or for an active military member's record, we don't want to be doing that when someone else is already

working on that. So this provides an opportunity if they're ... you know, if it's no but they're working on it, then they can put a note on it.

For the community partners for ... like we want to be working with people. We don't want to be treating people in silos. So we want to be working with the whole care team and if part of that care team is outside of the clinic, then we want to make sure that we kind of know who they are and, wherever we can, engage those individuals.

Q. And you said it. You said a very important phrase there. You said "you don't want to be treating people in silos".

A. Yes.

Q. What do you mean by that?

A. So there's a number of examples. You know, somebody might come to our clinic because they would like to seek services from a psychiatrist from a medical perspective but perhaps they have a psychotherapist in the community. So we want to make sure we're trying to engage with the private practitioner who is providing them treatment so we can make sure that it's not a silo, that they're siloing them in psychotherapy and we're only dealing with this. We want to make sure that

we're engaging that client's support system so they're not siloed in their treatment with their support at home where they don't know what's happening on the other hand at the clinic.

Q. And does this sort of silo extend to ... obviously it extends to the sharing of information.

A. Yes, yeah.

Q. And when I ask about sharing of information, at the front end for Veterans Affairs when a referral is made, is it important for your clinic to know that the veteran was treated in this OSI clinic in New Brunswick, he spent time in a residential treatment program in Quebec? Is it important to have that information right at the front end?

A. Is it important, absolutely, and if we ... and we will try to gain as much of that information also during the intake if we can't get it.

Q. Okay. And how do you start to sort of try to gain that information at the intake if you don't get it?

A. So during the intake we talk about the treatment that they've had in the past. We talk about the deployments. So we're building in one document as much as we can. So if it's come in from other sources at the intake, then we are compiling that information. So if we already have something we don't want

to be putting a client through it. If we already know all of their deployments from the referral package, we don't want to be interviewing that person on an intake assessment and putting them through ... having to go through it all again and trying to formulate their timelines when we already have it from a trauma-informed lens.

So once again if we haven't gotten everything, for whatever reason, we don't want to say, Okay, client, you are going to wait until we get everything. We need to also serve that individual who is in front of us. So we start to build it with the client.

Q. In practical terms, and we have this referral form and there's a checkbox that talks about included, yes or no, it says, OSI clinical services referral form, consent forms for the release of information, summary assessments, release medical report. It goes on and then it even says medication printout from Canadian Armed Forces pharmacy.

A. Yes.

Q. In practical terms, you're getting a referral from Veterans Affairs Canada to your clinic. Are you getting all of this information usually right out of the gate?

A. So if we can go up for a second.

Q. Sure.

A. So, for example, there may not be a summary of assessment if they've never been assessed before. Then the answer to that is going to be "no" because there isn't one.

Q. Yes.

A. If we can go down for a second. So some of the ... I guess the answer to your question is is that not always. This is what we strive to get.

Q. So ...

A. Yeah.

Q. And that's very fair. So I'm trying to get a gauge of the number of referrals that are coming from Veterans Affairs that are giving you a near-complete package, and what I mean by near-complete package are if the veteran saw a psychologist for prolonged exposure therapy while at the Canadians Armed Forces, if they saw a psychologist while at the Canadians Armed Forces, if they saw a psychiatrist in a clinic in New Brunswick, OSI clinic, how often are you getting all of that information with the referral? It seems to contemplate that you want it but how often are you getting it?

A. It would be a guess. I don't monitor this on a daily basis. I mean I certainly do see referrals coming in that are

sometimes hundreds of pages.

(15:30)

Q. Mm-hmm.

A. But on average I would say it's not ... I don't know, I'll say 70 ... 60 percent.

Q. 60 percent are ...

A. That's a rough guess.

Q. And I appreciate it's a rough guess. So you ...

A. I'd say 60 percent we're getting the information we need.

Q. Okay, and the other 40 you're left chasing stuff down.

A. Right, and the nurses do spend a lot of time kind of ... it's actually kind of become part of their job is to build the files in order to prepare them for their assessments.

Q. Would it be helpful to you if that was already prepared in the sense of a military veteran is ... at some point they leave Canadian Armed Forces. They become affiliated with Veterans Affairs. They have their medical record. All the consents are signed. They have access to it and Veterans Affairs has it. So in this scenario Veterans Affairs are in possession of the Canadian Armed Forces records even before they get to you. Would that be helpful?

A. Yes.

Q. And why would it be helpful?

A. Well, I mean if we're serving them to assess a client, then having all the information at our fingertips it's helpful.

Q. It gives a complete understanding of ... you don't have to ... I guess it says duplication of services.

A. Yes.

Q. So basically, you know that such and such therapy maybe worked at the Canadian Armed Forces. It may work here.

A. Absolutely.

Q. Such and such therapy didn't work at the OSI clinic in New Brunswick, so maybe we won't waste our time trying to do it here.

A. Yes.

Q. So does it make for a more efficient, effective care model for the military veteran?

A. Having access to information is always helpful. I will just ... if I can go back ...

Q. Yeah, sure.

A. You said maybe not do that. But we have to take into consideration if the person was doing prolonged exposure but maybe in that time there was other life stressors going on.

Maybe they weren't as motivated to do it at that point. Doesn't mean we don't try it again.

Q. Okay. And I notice that one of the services, for example, offered at the OSI clinic in Nova Scotia was couples/family resources?

A. Yes.

Q. What is that?

A. Veterans Affairs Canada allows family members to also seek supportive counselling if it's going to benefit the goals of the veteran themselves.

Q. Yes. Okay.

A. So that we would do psychoeducation and supportive counselling to family members if the veteran is already a client at the clinic. We would not see a family member if the client wasn't at the clinic, for example.

Couples counselling is if it's been identified that the couple's relationship needs support and that again it would benefit the ultimate goals of the veteran at the clinic then we have trained some of our staff in doing couple's counselling in order to internally refer to them to support that relationship.

Q. So I guess my question is more geared towards looking into the future and operations between all of these entities.

So there's a chart. Well, more than a chart. There are detailed notes from a social worker, psychologist, a psychiatrist that talk about someone that has spent time at Ste. Anne's in Quebec. They did a residential program. And a recurring theme over and over and over is the life stressor of the veteran. It's marital breakdown. It's trying to work on his relationship. It's a priority to that veteran. His wife is engaged, wants to talk to therapists, wants to talk to social workers.

Would having that information that comes to you from a referral be helpful in sort of trying to structure a treatment program for the veteran as it relates to this family/couples resources?

A. So I guess I'd go back to my comment that as much information as we can get is helpful.

Q. I'm going to look at Exhibit 261 and I'm going to look at page 31. So I understand that this is the referral form drafted by the OSI clinic ...

A. Yes.

Q. ... that is to be used by an RCMP entity making the referral for an RCMP officer.

A. Yes.

Q. What stood out to me last night was ... if you go in the middle of the page there's a section here that says, "Current health professionals involved in client's care: physician, mental health service provider." What is the purpose of having that there? And there looks to be a space to list the names of who they are.

A. So first off, the reason we created two separate forms was because some things that are available through Veterans Affairs are not possible to get through RCMP. Prior to about nine months ago we had one form and it caused a lot of confusion. So that's why we worked with our community partners, our referral sources to find out, Okay, what can we get and move forward with that.

The current health professionals involved in care. Can you just go up for a second? Just want to make sure I'm answering this right.

Q. Sure.

A. This is because on the ... if ...

THE COURT: Sorry, you want that page scrolled up?

A. It is. Thank you.

With RCMP there's less documentation. So with Veterans Affairs there's another document that comes with it that that

information would be included on but this is all we would get with the supporting documentation from RCMP.

MR. RUSSELL: Okay, so I just want to clarify, because when I looked back at page 29, which was the referral form ...

A. Yes.

Q. ... that was the only document that I saw that's a referral but I didn't see listed where it said current professionals involved or ...

A. It's a Veterans Affairs official form, not ours.

Q. So if Veteran Affairs sends you an additional form ...

A. What we created is a, Here's to help you. Veterans Affairs has their own forms they send as an official referral nationally. We created this for Nova Scotia.

Q. Okay, so as a rule, does Veterans Affairs always provide this other form along with your referral form?

A. Yes, because that's the one that says treatment, treatment or disability, and we would not proceed without those check-boxes.

Q. And does it list current professionals that are interacting or treating the client, do you know?

A. Honestly, I'd have to look at the form again.

Q. Yeah.

MR. ROGERS: Page 34.

MR. RUSSELL: Page 34? If we could turn to page 34. Is this the other form you're talking about?

A. OSI ... this is the one for ... can we go down a little bit? No, this is the one for the OTSSC. This is for active members of the military.

Q. Okay.

A. So that's why I'm saying if it's not here I'm making an assumption that it is on another form that they provide that's one of their forms.

Q. Okay. And I notice that on the OTSSC at page 35 it has a pretty generous space for additional comments and then if we look back at page 32, which is the RCMP referral, again it also has a pretty generous space for clients and it says: "Summary of client's current situation, mental health presentation, additional information regarding reason for referral, employment status, client and provider expectations." I'm not seeing that at page 29 of the Veterans Affairs referral.

A. And can we go ... thank you. This is the VAC ... and can we go ahead to the RCMP for a second?

Q. Which would have been page ...

THE COURT: 34.

MR. RUSSELL: 31. I apologize.

A. Yeah, thank you. So this would have ... I'm thinking this is why. Because when we engage with each of the partners these are things were also requested. Veterans Affairs didn't feel that they needed a lot of space to make additional notes, what they could provide to us was covered, whereas RCMP, they might have other characteristics and things that they felt they might need to add in the comment section.

(15:40)

Q. What I'm somewhat curious of is in the RCMP form it says "Client's current situation". Sort of the here and now, the existing client, how they're doing. And it says: "Mental health presentation, employment status, provider expectations." That seems to be pretty important information.

A. Yes.

Q. Is there a reason why that information applies to RCMP and maybe doesn't seem to apply when it comes to receiving a referral for Veterans Affairs?

A. It's not that it's not important, it's who it's screened by. So with the RCMP the referral is coming from nurses and it's coming from psychologists who sign off on it, whereas at Veterans Affairs, as we said earlier, there's many

different disciplines and it may not be within the scope of those disciplines, I'm assuming, in order to collect some of that information, including the presentation.

Q. So that's what I'm sort of wondering. So RCMP referrals are made by nurses and psychologists.

A. Yeah, they have ... their referral sources are nurses and then the head psychologist or psychiatrist signs off onto it and sends it to us.

Q. Do you know or are you aware of the rationale for why they want a nurse or a psychologist making their referral?

A. I'm not sure. It may be because the ... whatever they do for followups and things like that but I'm not sure.

Q. Is it possible that a nurse or a psychologist would have a greater understanding of client expectations, presentation, mental health? They might sort of understand the clinical portrait of the person they're referring and the importance of having them there?

A. It could be but we also do at that at the clinic as well when they arrive.

Q. You do it when they arrive.

A. Yes.

Q. I'm just ...

A. Our nurses are screening them as well.

Q. I'm just sort of trying to gauge a scenario where before you can even get the car on the road the keys are taken away. Basically, No, no, we're going to get a clinical therapist, he says he wants to see someone in the community, we're going to call up Joe Clinical Therapist and away we go.

A. Right.

Q. Is there value in the person, from your perspective, that's making the referral that has an understanding of what it is they're referring? And what I mean by that is they understand what a psychologist report means, what it means to ... what cognitive behavioural therapy is, what it means to have an occupational therapist, the importance of, say, a neuropsychological assessment.

A. So on one level, absolutely, but I think there's variables that are being considered that I might not know full scope on.

Q. Sure.

A. One of those variables I might think, or I assume, is that there's a different gateway between a referral coming from RCMP and a much wider gateway of what Veterans Affairs can send.

Q. Okay.

A. So if they're ... I think that if there is a request for mental health services from Veterans Affairs then there's less barriers in order to get that treatment whereas with RCMP there's other options and they do more of an assessment before the referral comes over because of the disciplines they have involved and then they make the decision.

Q. Okay. I'm going to ask you a little bit about wait times if a veteran becomes affiliated with the OSI clinic in Nova Scotia how quick is it ... and their need of psychiatrist services. Is there any wait time for them or do they get in right away?

A. So once again are we talking about any level or do you want me to focus on ...

Q. For example, a veteran is referred to the OSI clinic in Nova Scotia. The triage is done. They're ready to sort of engage and access the resources. They need medication adjustments or assessments as it relates to medication. How long before they see a psychiatrist?

A. So I can speak on current stance. So current stance, we would book out psychiatrists specifically no more than three months ahead, and we're meeting that right now. So it can take up to ... at this point I think we're at two months and three

weeks in order for the next person to be seen by a psychiatrist.

Q. So just so I get this right. So currently in Nova Scotia a veteran is affiliated with Veterans Affairs Canada. You have reports that talk about the need, the significant need for psychiatry services in Nova Scotia. They have significant life stressors. They have depression. They have PTSD. They have mixed personality traits. They have a history of non-compliance with medication. It's going to take them two months before they see a psychiatrist in Nova Scotia?

A. It will in Nova Scotia at the OSI clinic. Now there's other resources in the provinces and those are options also, but once again, the OSI clinic is not an urgent service.

Q. Okay, and I get that when we define "urgent service" it might be someone that's actively having suicidal thoughts or is making thoughts of going to engage in suicide, and I realize that the OSI clinic is not a crisis service. But you understand the concept of continuity of care, yes?

A. Yes, yes.

Q. You understand that if a military veteran spends time in a residential treatment program with a very structured environment with an entire continuity-of-care team - a circle of care that involves social workers, psychologists, psychiatrists,

occupational therapists, art therapists - is it important to continue that continuity of care as quick as possible when they transition back to the community?

A. So you're naming some qualities in there that we would bring our priority guidelines in for. So if someone was in an inpatient unit prior to coming to us, then most likely they're falling into a priority one and then we're making room within a week for that individual.

Q. That's what I want to ask about is sort of ... because when I heard you say psychiatrist services was two months down the road are there exceptions to that rule?

A. Yes, there is exceptions to that rule.

Q. And if you can explain those to us.

A. Yeah, so we have three priority guidelines. We use those guidelines in every step of the process. So if it's identified ... whether it's triage, intake, assessment, or if we get to a place where we're starting to have a waitlist for psychotherapy after the assessment, then we would, at all the stages, identify what priority level that individual is at.

So if they're a priority one we ... if we need to move somebody around, then we're getting ... we're seeing them within a week. If they're a priority two, then we're looking at

getting them in within a month, I believe it is, and then if it's priority three it's the next available appointment.

Q. Okay. And is there any discussion between the clinic and Veterans Affairs when it comes to sort of prioritizing some veterans over others?

A. Well, it's based on the information that we have. So we're assessing that individual. Veterans Affairs may make a recommendation of what priority they feel they were at but we're basing it on our definitions of what that is. So we're going to be reaching out to that client and gathering information.

Q. And so I guess as a general rule today, a veteran leaves a residential treatment program such as Ste. Anne's and they're referred to the OSI clinic in Nova Scotia and I know it's subject to various variables.

A. For sure.

Q. And I want to be fair to you on that. Is it more often than not that they would be given priority to psychiatry in the OSI clinic?

A. Yeah, and what we would do is we would be ... if we knew that this person was in a treatment facility, whether it is Ste. Anne's or another one, we're going to be advocating that we're brought into this prior to them being discharged because

we want to be part of their discharge plan. So the sooner we know that they're in a treatment facility, then we can be planning ahead of that and then have a conversation with that inpatient unit so we can have those plans set out. Not only for booking them in, in a timely manner but also about, Okay, when they ... when they arrive back at their home what do they need us to be doing? So we're not just looking at a report but we're actually speaking to somebody.

Q. Okay. So a veteran in 2021, I'm going to say out in the wild. And what I mean by out in the wild is in the general healthcare system in Nova Scotia. They want to see a psychiatrist on a steady basis to monitor compliance with medication, to revisit diagnosis. Are you able to comment on the average wait times for them to see a psychiatrist?

A. In community Mental Health and Addictions?

Q. Yes.

A. I'm not sure to tell you the truth.

Q. Would it be as efficient as what you can make happen to the OSI?

A. I make an assumption? No.

Q. Okay. Now why is that?

A. Just from my years of being in Mental ... or community

Mental Health and Addictions and I know that there is wait times which I believe are public. But I haven't reviewed them any time recently.

Q. So in general principles, is it advantageous to a military veteran that needs to access psychiatry services, is it to their advantage to go through the clinic as opposed to out in the province?

A. Military veterans have more resources available to them than the general public. So whether it is within the government system, the OSI clinic, or privately seeing a psychiatrist, each of those could be a reality for that individual. I might steer them toward either the OSI clinic or to private because those resources are available to them to do both of those.

(15:50)

Q. And when you say private psychiatrists they operate their own clinic outside of a Nova Scotia Health model working in a hospital?

A. Yes.

Q. Is that ... okay. Do you know if there are many private psychiatrists operating in Guysborough?

A. I'm not sure where each one is located.

Q. Do you think there are any that operate privately in Guysborough?

A. I couldn't tell you honestly.

Q. Do you think there are many private psychiatrists operating in Port Hawkesbury?

A. I would be guessing. So I'm going to say maybe no.

Q. Do you think there are private psychiatrists operating in Yarmouth?

A. There is private ... yes, there is in Yarmouth.

Q. There is? Okay.

A. Yes.

Q. Sydney?

A. Yes.

Q. Is it more common ... or is it more frequent than not ... is it fair to say that if a military veteran wants to access private psychiatry treatment they're going to get it a lot faster in a central ... if they're in Halifax as opposed to Guysborough?

A. I think it's a fair statement, but I'm not sure of the wait times on things.

Q. Is it fair to say that the Province of Nova Scotia, as a general rule, is having a tough time recruiting psychiatrists?

A. I would agree with that.

Q. Yes.

A. Yes.

Q. So the fact that they're having trouble recruiting psychiatrists as a general rule, they're not as common and plentiful as we would like.

A. I would agree with that, yes.

Q. And if I'm doing it sort of the logic and reasoning, could it be difficult for a military veteran to readily access a private psychiatrist in Nova Scotia?

A. I would say, yeah.

Q. So I guess option one, if they can get a psychiatrist through the OSI clinic in Nova Scotia, maybe is that the better option for them?

A. Certainly, if they would like to come to the OSI clinic and they were okay with kind of the priority level of when they were going to be seen then absolutely.

Q. In that vein about the psychiatrist, we've learned a little bit about neuropsychologists and they tend to be a bit of a unicorn in the sense of a lot of people can tell us about them but not a lot of people offer that service.

A. Mm-hmm. Yes.

Q. Does the OSI clinic in Nova Scotia offer the service of a neuropsychologist?

A. So as Dr. Rudnick said, we can do part of those assessments but we refer out. And as he said, because I don't have my pulse on this level of the care that Dr. Rudnick would, he hasn't had a lot of issues with getting them done privately but I don't know how many there are in Nova Scotia.

Q. Okay. Fo you know anything about sort of ... we've heard a bit about it takes a while to see one, it takes a while for those assessments to be done. Do you have any insight into that or ...

A. I do not.

Q. We've heard a little bit from Dr. Rudnick about sort of being aware to military veterans or patients that have problem- solving problems, I believe he said, when he referred to cognitive deficits.

A. Yes.

Q. So if you have a military veteran referred through your OSI service who do you send them to for assessment for cognitive ...

A. So for cognitive remediation I would be sending it to my occupational therapist.

Q. For testing to see what the cognitive deficits are.

A. To start off, yes, and from there, if it was decided that we would need to have a psychologist with certain disciplines and we did not have that in clinic, then we would advocate with Veterans Affairs to support that and to follow through with that.

Q. In your time at the Nova Scotia OSI clinic have you ever seen a veteran be sent for neuropsychological testing, cognitive testing?

A. Again, I don't have my fingers on that level but Dr. Rudnick referred to two cases this morning.

Q. Okay. Earlier on we heard some information about operations of the OSI clinic in 2016 and an interaction between the intake nurse and the Veteran Affairs case manager and there was some discussion about the OSI clinic in Nova Scotia and mindful back to 2016. My question is going to be about present day.

A. Sure, sure.

Q. There was some discussion about almost a prerequisite or a recommendation that the veteran have a family doctor before they can access psychiatry services at the clinic.

A. Okay.

Q. Is there any rule currently in place, or any sort of suggested recommendation, that a military veteran have a family doctor?

A. No.

Q. No? Are you aware of any past policy that would have had that?

A. Not policies, no.

Q. Are you aware of any sort of preference that might have predated you with past employees?

A. It wasn't a rule when I came to the clinic in February of 2018. I think that there may have been something that was in place prior to that. I don't have a lot of the history on it where it was a preference that they had some ... before a GP was at the clinic that they had a family doctor for seeing a psychiatrist at the clinic. But I don't know a lot about it.

Q. But it sounds vaguely familiar or ...

A. Just through ... like just kind of knowing a bit of the history of the clinic.

Q. Okay.

THE COURT: Let me ask you. So have you had that kind of discussion just in the last few days with anyone ...

A. About the?

THE COURT: About the probe about ... the questions about whether there was a practice or policy other than what you may have heard me ask Dr. Rudnick earlier today?

A. I've contacted the old manager, Derek Leduc, and ...

THE COURT: When did you do that?

A. We've had conversations within the last two weeks.

THE COURT: Okay.

A. And just what started it was does ... I wanted to know was the doctor thought up prior to the tragic events or after the tragic events and he supplied me with some information that it was thought up and in the works prior to the tragic events.

THE COURT: That is, adding a general practitioner.

A. Yes, general practitioner.

THE COURT: To your team.

A. Yeah. I was trying to find out did ... was this ... was the general practitioner put in place because of it or was it something he advocated before it.

THE COURT: But there was a note that was prepared by Ms. Tofflemire who had indicated that she'd had a conversation with the case manager and the case manager, VAC case manager said that she'll verify if he has a family doctor before proceeding with the referral. The file would be placed on hold

until then. That was October 6th, 2016.

A. So my understanding is that there was some rule or some guideline being put in the clinic at that time that ... I don't know who or what the preference was but that it would be preferable that somebody had or that they would only see people for psychiatric treatment if they had a family doctor.

THE COURT: I'm going to suggest to you there's a big difference between they won't or they should or they will.

A. True, yeah.

THE COURT: Okay, so who would know that?

A. I'm suggesting probably the past manager would know that.

THE COURT: Past manager?

A. Yes.

THE COURT: And, sorry, his name again was?

A. Derek Leduc.

THE COURT: Derek Leduc? Thank you. Sorry to interrupt.

MR. RUSSELL: No, no, that's fine.

THE COURT: All right. Thank you.

MR. RUSSELL: So I'm going to move to this ... I put it into inter-provincial transfers, and I know there's no such

thing necessarily, because everything has to come from Veterans Affairs. But if you have a veteran who is ... okay. In your experience with the clinic have you seen veterans moving back and forth of New Brunswick and Nova Scotia, New Brunswick and Nova Scotia, or other provinces?

A. You mean like physically moving back and forth?

Q. Yeah, or spending time in, say, New Brunswick, you know, so many days a month and then they're back in Nova Scotia.

A. I have one client at the clinic right now that they're spending a period of time in Newfoundland. Not moving back and forth, but in order to ensure consistency of care I've registered that professional in Newfoundland so they continue to see that person virtually.

Q. So you register them ...

A. Through the Colleges.

Q. Through the Colleges. So they're seeing whether it's a psychologist or mental health professional in ...

A. They're seeing ... sorry, they're seeing one of my social workers at my clinic.

Q. Yes.

A. But while he's in Newfoundland, instead of stopping his care, we've got privileges so she can continue his care in

... maybe I got to back up.

Q. Sure.

(16:00)

A. In the Province of Nova Scotia disciplines cannot serve another person if they're not on Nova Scotia soil. So if they spend a period of time in a different province they are unable to continue providing that support unless we get the privileges from their College. So we've gone through the process of giving that social worker privileges so she can practice in the Province of Newfoundland while that client is living in Newfoundland.

Q. Okay.

A. By virtually doing that.

Q. So it's to keep the consistency with your clinic ...

A. Yes.

Q. ... even though the patient is in ... or client is in another province.

A. Yes.

Q. Can you ever envision a scenario where there's an OSI clinic in New Brunswick, however the veteran spends a fair amount of time in Nova Scotia and they're fairly transient back and forth, where two OSI clinics in neighbouring provinces could

collaborate with one another, that they could almost sort of borrow, I guess that's the wrong term, but allow your psychologist to treat the veteran that's affiliated with their OSI clinic in New Brunswick. Has there been an example of that? Is it even possible?

A. I mean I do see some ... so what you're seeing is is that if someone lived between two provinces ...

Q. Yeah.

A. ... and they would access both clinics to do therapy. I see potential issues because when someone's building a therapeutic rapport and doing therapy with the other individual then, number one, therapeutic rapport is a good part of that. And taking somebody down ... someone starting treatment and then continuing treatment and then going back to a protocol somewhere else, that consistency is missing.

Now if it was supportive counselling in two different places I can see that a bit more to have that but I can't envision ...

Q. So am I getting from you that in some cases it may work, and in some cases it may not work.

A. Yes. Again, in my opinion.

Q. Okay. I'm just thinking of sort of almost a more ...

is it possible to sort of have a streamlined approach or do you always have to bring in Veterans Affairs in the sense that someone is affiliated with the OSI clinic in New Brunswick? They were set up with a psychiatrist, a psychologist, an occupational therapist.

A. Yes.

Q. However, there are periods of time where because mental health, it can be very fluctuating, there are period of times in Nova Scotia where there becomes to be a bit of a disconnect from their providers in New Brunswick. Can you have someone in Nova Scotia sort of assisting and facilitating the clinic in New Brunswick without reopening a whole new referral or without requiring New Brunswick to make a referral to Veterans Affairs if Veterans Affairs decide ...

A. We would always want Veterans Affairs to be part of that process.

Q. Okay.

A. But we would get the release of information signed so we would be able to communicate back and forth directly with the OSI clinic. And if there are any barriers get in place there, then even myself as a manager - not just in New Brunswick but any province - could work with the other OSI clinic's manager

with consents to get that information between clinics as long as the official referral came from Veterans Affairs.

Q. Okay. So in your experience has that ever been done?

A. Absolutely.

Q. It has.

A. Yes.

Q. So someone is affiliated with multiple OSI clinics?

A. Well, it's because they're transitioning to another, not that they're staying there. But they're transitioning to another one. So if the question is have they been involved with both at the same time, no, it's always been a transfer of care.

Q. So it always has to be ... you have to sever the relationship with one to get involved with the other.

A. That's been the practice. I haven't experienced that lots.

Q. Do you see that as maybe somewhat rigid, that you just have to cut ties with everyone you dealt with in New Brunswick in order to access services in Nova Scotia? You can't sort of have a little bit of both to assist with your transition?

A. And it could be just because we've never experienced it. We've never had a client living in both and needing to access both.

Q. Okay. But if you turn your mind to it would something like that be possible?

A. Honestly, it would need to be fleshed out quite a bit.

Q. I guess in your capacity is there anything preventing you from, say, having a discussion with Veterans Affairs and say, Look, rather than completely severing ties for someone that we have transitioning between both provinces maybe there's more of an easier way of doing this in the sense that they're still affiliated with New Brunswick, they still want to access their resources there, but in the meantime it's important for them to have resources in Nova Scotia, we're willing to facilitate that and allow it. Can that conversation happen with Veterans Affairs?

A. So I mean it's a bit of a clinical question and operationally ...

Q. Sure. Yes.

A. I could have those conversations. I think from a clinical lens it's a bit of a clinical question to find out what would be the barriers to care. Because really what we're doing is we're kind of splitting that care. Because in the moment we're not going to have all of the information to provide that person. Even with all of the documentation in the world, things

that happen in those sessions are important as well.

So I guess I can operationally see it. So, for example, if the person was taking part in a group in one province but then also getting their therapy in another province, then the group could be a benefit. And we're looking, actually, right now at a national group where it's online and people can ... whatever, Zoom in or whatever and take part in a certain group.

But if someone was doing a protocol and they're starting off with one person and they're picking up that protocol with another person, that's where, I think, my head is finding the barrier.

Q. Is it fair to say you're kind of doing that anyway in Nova Scotia? When you contract with a clinician in Port Hawkesbury to provide an outpatient service on your behalf with the Nova Scotia OSI they're still outside your clinic. They're assisting you in reaching the end goal. Is it much ... what's the difference between Nova Scotia assisting New Brunswick?

A. Sorry, can you repeat that?

Q. So basically if you have a patient in a rural area who wants to ... is part of your OSI clinic ...

A. Yes.

Q. ... and you are prepared to allow them to access a

psychologist in Port Hawkesbury who is not affiliated or an employee of the OSI clinic in Nova Scotia, correct?

A. Yeah. Yeah.

Q. So they have contact and resources with the Nova Scotia OSI clinic. They also have contact with a mental health professional outside of the OSI clinic in Nova Scotia. I'm just struggling to see how that's any different from here accessing professional help with an OSI clinic in New Brunswick and you're doing it here. What's the difference?

A. So I think maybe, perhaps, what I'm getting stuck up on is what services they're offering at each. So if, like, for example, someone's in session three of a prolonged exposure with a psychologist in Halifax and then they're expecting to do session four with a psychologist in New Brunswick that's kind of where my mind goes and I would see that ... it's not ... that's not the way that kind of therapy works.

Q. Okay.

A. But if it was they're doing their therapy, their one-to-one therapy with a clinician in one province and then they were in a group with another province I see my mind opens more up to that kind of thing.

THE COURT: Some services might be more amenable to

being split between locations and others you require the continuity of the same person to be effective.

A. Yes, that's what they are. Exactly.

MR. RUSSELL: Okay. That's fair. I'm just going to ask you a little bit about ... there was a paper that you had completed with Dr. Rudnick.

A. Yes.

Q. It was about, in the pandemic, using technology as a way to sort of reach out to clients.

A. Yes.

Q. And you've indicated that you've had ... it's brought up on the screen, Exhibit 265. You've indicated that there was some success with that?

A. Yes.

Q. And what were the advantages that you saw?

A. So I mean pandemic ... I always try to figure out the silver linings of COVID-19 and virtual care has been a silver lining. Nova Scotia Health, one of the things that they were working on as they head toward what is referred to as Direction 2025 was increasing virtual care. And pandemic did that in a matter of weeks to months, what was supposed to take five years. Because we needed to.

So the ability for us to move onto a platform that is already evidence-based and has evidence towards the validity of this ... so it wasn't about could it work, it was about getting people's buy-in of, This is something new. And when I say that, I say that about our clients, our partners, my team. Everybody kind of had reservations. Because I've been trying to advocate for virtual care, or increase virtual care, because of people in rural communities since I got to the clinic. So when I got to the clinic we talked a lot about telehealth. We do have telehealth platform.

(16:10)

Shortly after getting to the clinic I introduced a program called Medeo, which is another virtual platform that people can ... I keep on Zoom in to our Medeo intro from home. And that was something that was implemented at the clinic and being done prior to COVID-19. But COVID-19 increased the uptake by all parties to move to virtual platforms. So now with the Health Authority in Central Zone moving to a 50 percent ... being able to see a 50 percent in-person client rate, we're now starting to see a balance between in person, phone, and on virtual appointments.

Q. So are you able to gauge sort of ... are you having

any success with that?

A. Yes. Yes. I mean success as based on client experience and CROMIS data.

Q. Yeah. And it seems to be reflecting that it's being helpful to clients.

A. Yes. It is.

Q. Obviously with anything there are limitations. So what type of services are available virtually?

A. So in some capacity, all services. So a client has a choice of whether they want to be seen in person or virtually but, you know, psychiatry assessments can be done virtually. Or any assessment can be done virtually. All the different types of therapy we do have been done virtually and we've sought out evidence for each one of those things. Even our general practitioner can do some of their appointments virtually and then, if needed, bring them in person if ... or we do have some questions that are asked of the client of, Is this something that you need to be seen in person for? And then if they're not sure we can do it on phone or virtually and then if it's assessed we can bring them in for their appointment.

Q. Can you do the three gold standards in psychology by virtual?

A. Yeah, there was already a number of ... much evidence for prolonged exposure and cognitive processing therapy and COVID brought out emerging evidence on EMDR.

Q. So prolonged exposure and cognitive therapy you can do virtually?

A. Yes.

Q. Can you do EMDR virtually?

A. That's the emerging research.

Q. Okay.

A. But it has been ... they are doing it and finding some success with that.

Q. And what percentage of patients or clients are you finding are adopting this and taking this as a good thing?

A. Virtual care?

Q. Yes.

A. I think we're probably at the 50 percent mark, 50 percent in person and 50 percent still online.

Q. Okay.

A. Yeah.

Q. Would you agree that although it's a great stride forward it's certainly not a solution for everything?

A. It's not a solution for everything. It is a balance.

So clients always should have a choice of whether they want to be seen in person with pandemic protocols or virtually.

Q. So what do you see as sort of maybe some limits to ... what's the scenario where a client would need more than virtual care?

A. So for example, if ... well, number one, if the client's choice and they wanted to be seen in person that needs to be taken into consideration. If there was risk factors involved where we've identified that this person could have safety issues. That would not mean we would discount virtual, in my opinion, because if it was between the client not coming in at all or being seen virtually we would want to make sure we have a contract in place.

So, for example, we would know who's the other person in the house right now, what is their contact number? Reminding the client that if we see them decompensating, if they shut the laptop screen, then it is our legal responsibility where ... if we have concerns to call, like, the emergency services, you know, confirming the location they're at.

So those are cases that we would perhaps encourage the client to come in, but also if we were doing it virtually those are considerations we would have to take.

Q. Okay. If we turn to page 4 of Exhibit 265 this is ... I'm going to refer to your conclusions regarding your report. About midway through you said there admittedly there's a number of limitations and you set them out. First is the universal broadband, or basically internet access, as a natural barrier.

A. Yes.

Q. And I guess what you're getting at there is sort of rural regions as a rule maybe don't have the best internet service.

A. Yeah, if we can fix that, that would be great.

Q. We've really seen it in a provincial courthouse in the province.

THE COURT: Don't start.

MR. RUSSELL: So that's a fairly significant ... I mean you're striving for an end goal, and I see that, but right now there's some heavy qualifiers on that.

A. Yeah, so this is where we would ... we always ... when we're doing a virtual appointment we always collect a phone number in case of technology issues. So even psychiatric assessments. You know, we've learned how to do them on the phone if needed.

Q. Are you running into sort of scenarios where ... I

guess from different worlds we often see ... it's unfortunate that a lot of people that are struggling with mental health it seems to, a lot of times, go hand in hand with poverty. And it's great to believe that everyone has access to the internet or access to computers or even organized enough to be able to get that set up but, unfortunately, a lot of people that are struggling with mental health it goes hand in hand with going to the food bank.

A. Mm-hmm.

Q. Have you run into any issues with that?

A. We have not at the clinic. However, community Mental Health and Addictions in the early days of COVID put measures in place because they have a higher population of clients where they actually got cell phones and gave them to the clients.

Q. Okay.

A. And if they needed to do virtual then they gave them prepaid phone cards.

Q. All right. As well, you indicated ... you said generalized conclusions. Again, it's that ... about four lines from the bottom:

> Hence, generalized conclusions have to be qualified and well-controlled research is

needed to address processes, outcomes, and their predictors in relation to shifting to remotely delivered mental healthcare.

What do you mean by that?

A. So we need to do ongoing research on this. You know, this is a short period of time. It's highlighted as an issue. It's carrying it forth. It's not the end of the story.

Q. So it's sort of we're at a starting point, we need to really see how effective this is.

A. Yes.

Q. And how we can roll it out.

A. Yeah. And we need to build the evidence for or against it.

Q. I'm going to sort of end with a quick series of questions about barriers to healthcare and healthcare as it relates to a military veteran.

A. Sure.

Q. And, in particular, from rural regions and perhaps from a community such as Guysborough, which is historically African-Nova Scotian community.

A. Yes.

Q. Within Guysborough. Have you seen in your experience

with clients affiliated with the OSI that are in rural regions that may seem to be struggling with being able to access all the resources that someone is getting in central Halifax or Dartmouth?

A. I'm sorry, I'm thinking about ... you know, the first thing to comes to my mind is Amherst, for example. We have some clients in Amherst that they're kind of between Sydney, they're between Dartmouth. There is some private folks there. So sometimes I see them turning to go private because, you know, they have the options available to them and they're kind of just in the middle of everything. So I've seen that kind of thing.

Q. Okay, so there's ... I guess would you agree that part of your role as ... in the position you're in is to sort of start to remove barriers for military veterans of different backgrounds to be able to access services equally.

A. Absolutely.

Q. And part of that is the concept of setting up that satellite clinic in Sydney.

A. That and virtual and whatever else we can do, absolutely.

Q. What can allow you to do your job ... and in a perfect world you'd be able to remove every barrier. A military veteran

from Guysborough would be able to access the same resources as a military veteran who lives nextdoor to the OSI clinic in Dartmouth. If that's the perfect goal what do you need or can assist you in getting there? And don't be shy.

(16:20)

A. I think that there's ... I mean I'm just thinking off the cuff here to tell you the truth. But, you know, if we really expanded it to make sure that anyone who was seeing a military veteran, private or public, had a basic level of knowledge that there was ... you know, it was well known no matter what discipline it was. We knew that they had the qualifications to treat that individual and that ... and again, private or public. Because, you know what, an OSI perhaps doesn't have to be under one roof.

And the HR, psychiatry resources. So we need more psychiatrists in the province. To some degree, we need more psychologists in the province as well. I would say those are the two particular disciplines, as well as general practitioners for medical care.

Q. And I guess this is both ... and I recognize that you receive your funding from Veterans Affairs Canada, which comes from a federal bank account but, in general, from what you see

as well, Nova Scotia can assist generally in those aspects of more psychiatrists, more psychologists, higher levels of qualifications?

A. Ph yeah, I think it's everyone's part to play in that. It's not just one person.

Q. Okay.

A. Yeah.

Q. No further questions, Your Honour.

THE COURT: Okay. Ms. Grant?

MS. GRANT: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. GRANT

(16:22)

MS. GRANT: Good afternoon.

A. Hello.

Q. Hi. My name is Melissa Grant and I'm representing the Government of Canada, including various federal entities such as Veterans Affairs and the Canadian Armed Forces.

Just wanted to confirm a couple things. The form that my friend had up and we were talking about the referral form. You don't know if that was in use in 2016-2017, do you?

A. Sorry ... oh, the OSI's referral form?

Q. Right.

A. I know it was predating me in February of 2018. I don't know if it was there in 2016.

Q. So we've talked about that VAC is the funder in this situation and that if VAC is the ... and the referral source for veterans. If VAC is, say, on board with funding someone's treatment at an OSI clinic you would agree that the client can, at any time say, Thanks but no thanks.

A. Yes, that's the client's right.

Q. And would you agree that issues like wait times for mental health treatment, access for mental health treatment, the recruitment and retention of the professionals, that that's an issue for all Nova Scotians, not just military veterans?

A. I would agree.

Q. And in terms of the discussion you had earlier about wanting to plan for a discharge if somebody was coming from, say, Ste. Anne, I know you haven't had that experience personally ... or dealing with Ste. Anne. Or have you dealt with Ste. Anne?

A. We haven't dealt with Ste. Anne's but we've dealt with other inpatient treatments where we've done that with them.

Q. Okay. So you had indicated that ideally you'd want a

discharge plan in place, I think.

A. Well, it's not that just we want it. Any treatment facility should be doing that.

Q. Right.

A. So we would just like to be part of the discharge planning that they're doing when the person returns if we're part of their care. So the earlier that we can get involved, if that is known, and we understand if it's not, but if they're discharge planning most likely that's known. Then we would love to be involved in that piece.

Q. So you're planning ahead.

A. Yes.

Q. So would agree that it would be highly unusual for somebody who left your OSI clinic, did a residential treatment centre, and then moved somewhere else? Effectively short-circuiting your plans for the future.

A. And that is a possibility.

Q. And would you agree with ... you were here. We saw you here earlier today. So for Dr. Rudnick's testimony. But would you agree with one of the statements that he made, which is that the driver of the care is the client?

A. I agree.

Q. Those are all the questions I have. Thanks.

THE COURT: Thank you. Mr. Anderson?

MR. ANDERSON: No questions, Your Honour.

THE COURT: Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(16:25)

MS. MILLER: Mr. Daigle, you were here this morning. You heard me introduce myself. I represent the late Brenda Desmond through personal representative, her daughter Chantel, and also Aaliyah Desmond.

A. Yes.

Q. Lionel Desmond's daughter. Just a couple questions for you.

I wanted to talk about consents, consent forms in the package of information, Exhibit 261, that's been supplied. I'm looking at page 23 of that exhibit. Exhibit 261, page 23. And if you could ... yes, thank you, page 18. So it says, "Obtained consent to disclose personal health information consent forms."

A. Yes.

Q. At a minimum we (meaning the OSI Nova Scotia clinic) require

written consent to disclose information including the assessment report to the referral source. If the client declines the assessment cannot proceed because the referral source is also our client.

A. Mm-hmm.

Q. And we heard questions to Dr. Rudnick this morning about what would happen, would it just stop, and he said, We would engage in conversation and explain why. And he's not seen that happen.

But then it goes on to say, "It is often helpful to obtain consent to communicate/share a report with family physician and any other care providers involved with the client." So I take from that you're anticipating care providers outside of the OSI clinic.

A. Yes. Yes.

Q. And community.

A. Yeah. Can I speak on that for a second?

Q. Yes, please.

A. It's something I wanted to highlight, actually. Thank

you for reminding me. So the consent here is actually ... it's called a Friends and Family form. It is an automatic form we ask at the point of intake. It is something not just with the OSI clinic but all of Mental Health and Addictions and is part of what we are complying with Accreditation Canada. So at the early part of treatment we are asking about friends and family who are supporting them and the changes they are trying to make, gathering their name and their contact information and the relationship.

And if they say, No, there's nobody, no, I don't want to put anyone in, we put a line through the piece of paper and we still put the blank paper on the health record to show the rest of the team as they go through care that they've been asked and so we can continually throughout saying, Hey, I noticed you didn't have anyone before, just wondering, can we check in on that again?

Q. Okay. And that Friends and Family form as you've just described it, it strikes me that that's the form that you would need completed and with the authorization from the client to allow your clinic and relevant treatment providers to access the collateral information from family and friends?

A. So it's a bit different. So it can be that form.

That's an automatic trigger.

Q. Yes.

A. It can be any consent. They can add a family member to any consent form. Or it can also be ... you know, for example, if the client is in the room with them. We wouldn't need a consent for that because they're in the room.

Q. Of course. So that sort of takes me to my next question. How many consent forms are there for a client potentially to have to complete and when would those forms ideally be completed?

A. So there is ... at the point of triage we're talking about the welcome package.

Q. Yes.

A. And in the welcome package there are at least three consent forms: consent for treatment, consent for CROMIS, and consent to release information. And that's either mailed out to them if it's a virtual appointment after being discussed by one of the nurses or it is done in person with them if they're coming in for an in-person intake.

Q. Okay. And the consent to release information form ... we talked about the consent to receive treatment. Then the CROMIS form, which is your metric measurement for success. But

the consent to release treatment, is that a broad-based consent to release information, rather, to release information?

A. That ... yeah. There is a broad-based form. Because throughout their time with treatment there might be new things. So for example, there is ... through the veterans community there is a third-party contract, I think it is, called the March of Dimes that Veterans Affairs has contracted with that they do a portion of the work and that are asking us to complete forms. Because they're not technically Veterans Affairs we would need to get a consent to release information to these March of Dimes folks, but that might not be done at the start of treatment. That might not happen for six months.

So that's when this general form to release information would come out and we would just get that filled out each time the client had a new person that he or she would like to release information to.

Q. Okay. So when we go back to this exhibit at page 18 when it says: "It is often helpful to obtain consent to communicate, share, report with family physician and any other care providers involved with the client." So if we focus in on that circle of care in the community ...

(16:30)

A. Yes.

Q. ... family doctors and care providers with the client. What form or forms need to be signed to release information to those folks and when would they be signed?

A. So, technically, in the Province of Nova Scotia you don't need to consent to share information with a family doctor.

Q. Okay.

A. Okay.

Q. So why does it say here ... I'll just, as we're on that, why does it say here it's helpful to obtain consent to communicate share, report with a family if technically you don't need it?

A. Because we also want to highlight the fact that a client has a choice. So if the clients specifically state I don't want you sending things to the family doctor then we need to start having those conversations as Dr. Rudnick said ...

Q. Okay.

A. ... about the benefits of that and about not siloing treatment.

Q. Okay. All right. So technically you said technically you don't need to have that consent with the family doctor but then other care providers, when would that form ... is that the

same form as the one that authorizes the clinic to release information to the family doctor?

A. Or March of Dimes or whatever.

Q. Okay.

A. It's one of those ones that you can list a number of people on.

Q. Okay. And you can circle back to at later dates to add people on?

A. And you can always fill a new one out. There can be\ multiple of these, because any ... at any point in their treatment a new person may come up that they would like to release information to.

Q. Okay. So when it goes on to say: "Note that a separate consent form is required for each individual and must specify the information to be shared explicitly."

So I understood you to say there's a general form and you just add people's names or entities on that form, but this leaves me with the impression that there are separate individual forms for disclosure to different people.

A. Okay. I may be ... I'm sorry, I think I'm getting myself mixed up. The driving... my old job there was multiple ones, Driving while Impaired Program where we were putting

collaterals. I think the one that we're now using with the Mental Health and Addictions it's one per page. But it's the same form, we're just filling it out multiple times.

Q. And that is done ... I guess some are collected permissions at the beginning?

A. So at the beginning would be the CROMIS for outcome measures ...

Q. Yes.

A. Consent for treatment which is a different form.

Q. Yeah.

A. And then it's the consent to release information to others, so it might be Veterans Affairs. It could be ... you know, if they want to fill one out if they're more comfortable filling one out for their doctor then we'll fill one out even though we don't need to have that or whoever else. Because any client could have a number of people that they would like to release information to but we will not release that information unless we have a signed form.

Q. Okay, I appreciate that, and just structurally I'm trying to grasp are we ...

A. Absolutely, it's not easy.

Q. As we are trying to balance, you know, privacy and

administration burden and, you know, things not falling through the cracks, are we talking about every single person who's going to get any information needs a separate form or is there one form with multiple people on it that are checked off or taken off? I'm not clear from your evidence now.

A. Yeah, no, it's one form with one person on it and it would have to be signed for each one. So, for example, if the person was seeing a psychotherapist in the community and if we were going to send them the documentation or if we were going to ask them for documentation and we needed to send them a copy of our release of information form, then we can't send that with other people's information on it so we need to send the one that has their name on it whereas, for example, the Driving While Impaired program in another position where I was confused, we wouldn't be sending it to anybody else so it would just be going in the health record.

Q. Okay. So I think you've answered my question. I was going to ask you why do you have separate forms if, in your prior, employment you just had one form but it's to ensure that you're not disclosing other potential recipients of the client's information?

A. Yeah. Which is also breaching confidentiality if we

were.

Q. Okay. Thank you, that's helpful.

My last series of questions is around accessing and sharing information outside of the clinic. You said it's not an urgent care facility. It operates Monday to Friday, 8 to 4:30. If a patient or a client, rather, is in crisis on the weekends or evenings, they would have to go to an emergency room or access the provincial mental health crisis team?

A. Or the Veterans Affairs Assistance Line, as well, which I had forgotten about.

Q. Okay. So there's three things: the Veterans Affairs Assistance Line, the emergency room, or the provincial mental health crisis team?

A. Yes.

Q. So if you have a client that finds themselves in crisis and accesses one or all of those options after hours, how ... well, I guess with Veterans Affairs they would know about you, but if it's an emergency room or the provincial mental health crisis team, how do those entities get access to your records at the OSI clinic which would likely inform them in terms of the crisis that the client is presenting? How would they get access to your records?

Say, it's Saturday afternoon and you have a client in crisis who's in an emergency room in Guysborough, how would they, if at all, be able to access the OSI Nova Scotia records of relevance to help inform their diagnosis and treatment?

A. So how would they ... they ... so we're part of the Health Authority so we're on OneContent or, from a shared portal, they could access one ... if a different part of the province with MEDITECH, for example, they could go through a SHARE portal and view our records as well.

Q. Okay, so in Halifax is it that they would go through One Choice?

A. OneContent.

Q. OneContent.

A. It's the name of the health record.

Q. Okay. And outside of Halifax?

A. MEDITECH.

Q. They would go through MEDITECH.

A. Now Central Zone I should say. So, for example, Enfield to the tip of Cape Breton and then the other way.

Q. Okay. Yeah. That Central Zone is one ...

A. OneContent.

Q. ... OneContent?

A. Yeah. And if there's previous documentation it was called HPF ...

Q. Okay.

A. ... Patient Horizon File. It ...

Q. So currently now in Nova Scotia emergency room providers can go online whatever of those two systems would be applicable given their geographical location to access records from the OSI Nova Scotia clinic?

A. That's my understanding, yes.

Q. Okay. And what kinds of records would they be able to access, all of them?

A. Yes.

Q. Okay.

THE COURT: Ms. Miller, I'm going to stop you just for a second ...

MS. MILLER: Yes.

THE COURT: ... because I have a question that just follows on that.

MS. MILLER: Yes.

A. Yeah.

THE COURT: So you have an individual who's referred ... best example I think is a veteran that comes out of the OSI

clinic in Quebec, he's been in Ste. Anne's for two and a half months, he gets referred to your clinic. You wind up with his discharge summary, you wind up with the closing notes of the psychiatrist, the closing notes of the general practitioner, any closing notes, observations and nursing notes of the psychologist, he goes through your clinic to the point where there's an assessment, then he winds up in the Emerg in some place in acute distress and the doctors in Emerg want to know what's going on with this fellow, will all of those documents that I just referred to be accessible to the doc in Emerg?

A. Anything that's sent to our clinic as part of the referral package, on the day it arrives will be processed and sent to the health record.

THE COURT: So it would be ...

A. Yes.

THE COURT: ... within a short period turnaround time, all of it would be available for them to be able to access?

A. Yeah.

THE COURT: And would they have to know where to go to access? For instance, he winds up into emergency and he's in distress and you go, Well, we have the fellow's name, we know he's a vet, we have some reason to believe he may have been to

the OSI clinic, I mean will they know where to go and look for that information? Is it that kind of common knowledge or is it intuitive ...

A. Yeah, so, I mean, you can ... Sorry.

THE COURT: Go ahead.

A. So I'll back it up. So it comes in, we process it and send it to the health record, make a copy of it so we're not delaying the nurses being able to see it.

THE COURT: Right.

A. And then there should be like a front page of all of their visits. So they're going to see ... they should see ... like, for example, in an emergency room they should see a notice that there's something opened at the OSI clinic.

THE COURT: Gotcha.

A. And then under the referral or the referral documentation section of that then they should be able to go in and see all of that stuff.

THE COURT: And they'd have to start hunting it down but ...

A. Yeah, it's ...

THE COURT: ... there's breadcrumbs ...

A. ... definitely not a perfect system.

THE COURT: ... so to speak, they would be able to see it?

A. They should be able to see it, yes.

THE COURT: And they should be able to follow it themselves?

A. Yeah.

THE COURT: And eventually get to it all.

A. One Patient-One Record will be better because having two records in the province is not ideal.

THE COURT: I understand that. Yeah.

A. But they should be able to see it.

THE COURT: I think we're going to deal with that tomorrow perhaps but, anyway, but thank you. Sorry, I ...

MS. MILLER: No, you're following along my line of questions, Your honour.

A. If you could fix that too, that would be great.

THE COURT: Well, you know, if it's challenge, we'll look at it.

MS. MILLER: So just to tidy that up a little bit for my own brain.

A. Yes.

Q. There were ... if I'm an emergency room doctor in

Guysborough and Cpl. Jane White comes in, retired, and is in an acute mental health crisis and I type her name into ... I'd have to go into both systems, I guess, to see what might be in them, MEDITECH and the One Choice?

A. OneContent.

Q. Sorry, OneContent.

A. Sorry, I'm processing your question.

Q. Yeah. I'm in Guysborough, I have a veteran in front of me who's in a mental health crisis. I enter her name into a ... I'd have to go into two systems.

A. So ... okay, so if it happened in Central Zone ...

Q. Yeah.

A. So remember, we're a provincial clinic so that means we have psychotherapy happening in Cape Breton under one health record and we have all the other stuff happening in Central Zone. So what I've done knowing that I want and I feel most comfortable with everything being on one health record. I don't want their psychotherapy only up on MEDITECH and the rest of their treatment only in Central Zone.

So what I've done is I've created a bit of a hybrid model through the Health Authority's support and a lot of work, to make sure that we shadow everything that happens in Cape Breton

in on OneContent to make sure if someone is going on OneContent they can see the whole client care in one place.

Q. Perfect. Okay, I've got it. Thank you.

A. Yes.

Q. And then the flip side of that is somebody comes out of an emergency room on the weekend, how do you, back at the OSI Nova Scotia clinic, find out about that visit if they don't tell you?

(16:40)

A. So it's regular checking. You know, people are prepping for their sessions, so they're going on to the health record and they're doing a review, especially if they're coming to see psychiatry ...

Q. Yeah.

A. ... it's just ... it's part of their practice.

Q. So is there a flag that would be put on the system, you know, Cpl. Jane Smith is seen in Guysborough emergency and that gets flagged in the system? We understand that emergency room visits would get pushed out to the family doctor of record ...

A. Right.

Q. But in terms of your clinic being able to see that.

A. I don't think we get an automatic notification.

Q. Okay. So it's left to the individual making sure they go online to the electronic record of choice?

A. Yes.

Q. I mean in this case they would have to check several different places, right? Because you're in Halifax but you could be dealing with somebody in Guysborough, somebody in Yarmouth, somebody who's in the Central Zone. So your individual folks would have to take that initiative to go and look to see?

A. Yes.

Q. Okay. Thank you.

A. No worries.

Q. That's helpful. Appreciate your time.

THE COURT: Mr. Rodgers?

MR. RODGERS: No questions from me, Your Honour.

THE COURT: I know that ... Mr. Rory Rogers, do you have questions or are you going to defer?

MR. ROGERS: I was going to defer if I could, Your Honour.

THE COURT: Well, that's what I thought. Thank you. Mr. Adam Rodgers?

MR. RODGERS: Thank you, Your Honour. I have no questions for this witness.

THE COURT: Thank you. Mr. Morehouse?

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

THE COURT: Ms. MacGregor?

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

THE COURT: All right. Mr. Rogers, it looks like you're still up.

MR. ROGERS: That was a short deferral.

THE COURT: Thank you.

CROSS-EXAMINATION BY MR. ROGERS

(16:42)

MR. ROGERS: Mr. Daigle, you referred in response to some of the questions that VAC is the funder of the OSI clinic and is also the referral source, and you also referred at one point to the MOU. Could we turn up Exhibit 267, please? I won't take you to the end of this document, Mr. Daigle, but this is a 2015 document that's titled "Memorandum of Understanding - Operational Stress Injury Clinic Operational Agreement between the Department of Veterans Affairs and the Nova Scotia Health Authority".

Is this the MOU or the memorandum of understanding you were referring to?

EXHIBIT P-000267 - OSI CLINIC - OPERATIONAL AGREEMENT

A. Yes, this is it. I'm hesitating because I'm not sure if it's the most recent one which would just have some pen marks on it when it was updated after five years.

Q. Okay. And then could we turn to page 5 of that, please, and zoom in on the referral section, section 5 if you would. So this references that the department, which is defined at the outset, is the Department of Veterans Affairs, will have the sole discretion to determine which clients will be eligible for treatment at the clinic?

A. Yes.

Q. So is this the basis, the fundamental basis, that Department of Veterans Affairs funds the clinic and provides the referrals?

A. Yes. Clients cannot self-refer.

Q. Okay, thanks.

Then the second area I wanted to touch on is the one that you covered a moment ago in response to some of the questions from Ms. Miller and Judge Zimmer, it's in relation to the healthcare records. And I know the Inquiry is going to hear

evidence from individuals at Nova Scotia Health who can speak to those issues, but I just wanted to touch on a few areas just to make sure that we understand your understanding of the systems in place.

So you referred to the Central Zone and a health record system being available called OneContent. So currently what's the Central Zone of the Nova Scotia Health Authority?

A. Central Zone starts at Windsor, Nova Scotia and goes to Enfield, Nova Scotia or just before Enfield, Nova Scotia, out to Middle Musquodoboit/Sheet Harbour and then Halifax.

Q. So then all the facilities within that Central Zone, or the former district, then have OneContent as the electronic document management system?

A. Yes.

Q. And then you also referenced MEDITECH and this Inquiry has heard evidence of that system being available. So is that a comparable electronic health record system to OneContent but just in other parts of the province?

A. Yes.

Q. And then I think you made reference to this, but I wanted to make sure that we have clarity. You indicated that within your clinic you have taken steps to ensure that you and

all your clinicians and healthcare providers have access to both. How have you done that?

A. Just going through kind of IT in-trainings. And just because we're a provincial program we could provincially be seeing people so I felt it was important for the team to have access to everyone's health information.

Q. Okay. And then when you are entering information on the patients who have been referred in to you by VAC or the RCMP, you're entering it on to which system?

A. OneContent.

Q. Okay.

A. Yes.

Q. And, again, if this is outside your area of knowledge that's fine, but you, yourself, referenced the SHARE Program and again, the Inquiry has heard evidence about the SHARE program. Do you know what SHARE does?

A. The SHARE portal is a place where you can go in and you can view the different health records if you're in different parts of the province even if you don't have access to them.

Q. So if somebody is in a part of the Western Zone in southwestern Nova Scotia and has access to MEDITECH but is looking for information in the Central Zone, it's the SHARE

system that allows them to access some information on the OneContent system. Is that your understanding?

A. That is my understanding, yes.

Q. Okay. And again, I think we'll hear more about that tomorrow.

Lastly, you referenced the Sydney satellite clinic, of the provincial OSI system. When you came on in your position, how was that clinic operated and what have the changes been since you started in your position?

A. When I arrived to the clinic, a team member or two sometimes was flying for the day to Cape Breton in order to see clients for individual sessions and I changed that. So I think within three months I stopped that and I moved it to virtual or in-person, using not just telehealth but also the Medeo platform as well.

So I did a lot of engagement with our partners, presentations and engagement with my team in order to kind of start normalizing virtual care as well.

And then by July ... so I started in February, by July I started the engagement in Cape Breton with the key stakeholders, so Veterans Affairs, the military, and OSIS in Cape Breton, and then engaging my national network in order to get funding to

start building the clinic in Cape Breton.

Q. Does that building of the clinic include the hiring of clinicians who are based in the Cape Breton ... in the Sydney area?

A. Yes. So when the clinic opened it started with one social worker, knowing that the rest of the treatment, psych assessments and GP, everything would be virtually or in-person still from Dartmouth as it is now, and now there is two full-time social workers and an administrative assistant in the area, and the .5 vacancy for a psychologist.

Q. And has that growth in the clinicians been accompanied by a similar accompanying growth in the clients that are coming into the clinic?

A. Yes. Oh yes. Build it and they will come.

Q. And I assume those are based in the Cape Breton area?

A. Yes, anyone that's going in to the Cape Breton area is seen in Cape Breton.

Q. Okay. Thank you.

A. You're welcome.

THE COURT: Thank you, Mr. Rogers. Anything further, Mr. Russell?

MR. RUSSELL: Nothing, Your Honour.

THE COURT: All right. Thank you.

Well, it's turned out to be a bit of a longer day than everyone expected.

Mr. Daigle, we appreciate your attendance today and the time you've put in to prepare and review the documents before you appeared. It's very helpful to us to be able to understand fully the intricacies of the intake and the sharing of information, and I certainly appreciate the comments that you said about One Person-One Record/One Record-One Person. I appreciate how that will all work out. And I think we're going to hear some evidence about that tomorrow or what the plans are in that regard as well. You may be able to tune in on the webcast tomorrow and be informed. Anyway, we very much appreciate your time. Thank you for coming.

A. Thank you, Your Honour.

THE COURT: All right. Thank you. Stay well.

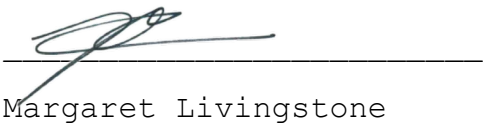
WITNESS WITHDREW (16:50 HRS.)

THE COURT: We'll adjourn for the day until tomorrow at 9:30 then. Thank you.

COURT CLOSED (16:50 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.



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