EXPLORING THE EXPERIENCES OF BLACK NOVA SCOTIANS WITH INVOLUNTARY PSYCHIATRIC CARE THROUGH AN INTERSECTIONAL LENS

by

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.

Dedication

This work is dedicated to all who have experienced involuntary psychiatric care throughout the years, and especially to the Black Canadians with serious persistent mental illnesses. To my participants, thank you for bravely sharing your stories.

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Abstract

This qualitative study aimed to hear the experiences of diverse Black Nova Scotians (DBNS) who have undergone involuntary psychiatric care (IPC). Help-seeking, stigma, trust, community, family, and health system were investigated. A narrative approach was used in six semi-structured interviews. Results were examined using an intersectional framework and Minority Stress Theory. Results show trust and help-seeking are interconnected in the times leading to and during IPC. Family and trust were found to be essential aspects of initiating help-seeking. Help-seeking is fleeting and degrades with illness. Stigma is present after IPC ends and relates to trust. Law enforcement and crisis services were prominent in all participants' pathways of care. Six recommendations were given to support DBNS within the involuntary mental health care system, including creating a Black Pathway of Care, reducing the gap between inpatient and outpatient services, and decreasing the reliance on law enforcement for the care of DBNS.

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Chapter 1: Introduction

To be Black and mentally ill[1] in Canada is not a neutral experience. Historically, enslaved Black people were thought to be immune to mental illness as they were not privy to the modern stressors that plagued White men, like owning land and engaging in commerce (Davis, 2018). Further, Antebellum "scientists" reasoned that the increase of diseases of the mind in White people compared to Black was that the minds of White people in 17th century America were "…brought into much greater activity and made of 'more delicate fiber' than that of [B]lacks[2]" (Pendleton, 1849 as cited in Krieger, 1987, p. 263). At the beginning of psychiatry, as we know it, several diagnoses were given to enslaved Black people who fought against their captors: drapetomania, given to enslaved people who ran away, and dysaesthesia ethiopica (or rascality), which was given to enslaved Black people who were deemed to be insensitive to punishment (Willoughby, 2018) and had trouble staying awake (Cartwright, 1850, as cited in Krieger, 1987), and exhibited "violent outbursts with destruction of property" (Jarvis, 2012, p. 230). A

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[1] Starting in the 1970s, the identity-first language movement began to provide a "non-harmful" way to refer to people with disabilities (Titchkosky, 2001). However, more recently, disabled people have been pushing back against this movement to regain autonomy in the conversation over their illness and to highlight the integral aspect their disability plays in their identity (Archibald, 2021; Botha et al., 2021; Titchkosky 2001). This author will use identity- and person-first language throughout this document, led by participant preference and grammatical flow.

[2] In the following document, the "B" in Black will be capitalized when referring to people of African descent to recognize that Black refers to a group of people with a specific racial history rather than referring to the colour "black." Additionally, "White" will also be capitalized as this group of individuals, descended from Europeans, has a unique history in North America and globally. These choices are derived from guidance from Ewing (2020) and Nguyễn & Pendleton (2020).

popular article in 1843 cited that “insanity” rates in Northern Black Americans were higher than in their Southern counterparts (Nott, 1883, as cited in Krieger, 1987). These Black-specific “disorders” demonstrate that the trends in 17th and 18th century psychiatry mirrored the political environment of the United States, fluctuating to serve the agenda of the powerful, and relied on reductionist and biological underpinnings for differences in diseases between Black and White Americans, rather than looking at social and historical pathology for differences between races (Krieger, 1987). Black physician, Dr. John S. Rock brought attention to this fact during his lecture tour in mid-1850 New England, stating that “slavery had nothing to do with innate [B]lack cowardliness but everything to do with [W]hite military superiority (Rock, 1850, cited in Krieger, 1987, p. 271).

Into the 20th century, descendants of the African diaspora were seen to be dangerous to “White” society (Maynard, 2017; Taylor et al., 2019) and were over-diagnosis with psychosis (Adebimpe, 2004; Jarvis, 2008) and under-diagnosis of affective disorders (Jarvis, 2012). A salient example is the treatment of the diagnosis of schizophrenia during the American Civil Rights movement. The diagnosis of schizophrenia was once reserved for artists exhibiting “genius” and housewives who were not ecstatic about keeping house (Metzl, 2011). Between the 1960s and 1970s, with the rise of the Black Power and Civil Rights Movements, the diagnosis of schizophrenia mutated from a diagnosis of artistry or melancholia to a diagnosis for Black men active in the Civil Rights Movement, whom White psychiatrists viewed as belligerent and angry. This diagnostic reclassification can be seen in Figure 1, where, in an advertisement for the antipsychotic Haldol in an academic psychiatric journal, a Black man is pictured lunging at the viewer with the “Black Power” fist and a menacing look on his face. The advertisement text states, “Assaultive and belligerent? Cooperation often begins with Haldol (haloperidol)” (Haldol Advertisement, 1974, as cited in Metzl, 2011).

Figure 1

Advertisement for Haldol from a 1974 issue of the journal Archives of General Psychiatry

Note. Haldol Advertisement, 1974, as cited in Metzl, 2011.

As modern psychiatry progressed from the 20th century into the 21st to include policies on providing culturally safe care, still-present racism and ongoing implicit biases about caring for ethnically- and culturally- diverse populations became more covert within the disciplines of psychiatry and psychiatric nursing (Louie-Poon et al., 2021). However, the surveillance and pathologization of the Black body and mind continued into modern medicine and psychiatry (Kanani, 2011). These views are seen, in part, in the involuntary psychiatric care systems.

Involuntary Psychiatric Care

Involuntary psychiatric care refers to mental health treatment provided to an individual against their will. This care may be provided in the hospital, for involuntary psychiatric assessment or admission, or in the community, as is the case for Community Treatment Orders (CTO). In the current study, both types of treatment are referred to as involuntary psychiatric care.

In Nova Scotia, involuntary psychiatric care is governed by the Involuntary Psychiatric Treatment Act (IPTA) (Province of Nova Scotia, 2015). IPTA (2015) specifies that an individual may be eligible to be held for assessment or admitted involuntarily if they are threatening to, attempting to, or have recently caused serious harm to themselves or others, or, because of their mental illness, are "…likely to suffer serious physical impairment or serious mental deterioration, or both…" (IPTA, 2015, p. 6). Furthermore, the assessing physician(s) has deemed that the person would benefit from psychiatric care. However, the individual is not able to receive this care voluntarily because, due to their mental illness, lack capacity to make treatment decisions (IPTA, 2015). Involuntary assessments and admissions are time-limited but can be renewed if the conditions above continue to be met. If an individual's treatment can be provided in the community, but they continue to lack capacity to make treatment decision they may be placed on a Community Treatment Order (IPTA, 2015).

A Community Treatment Order (CTO) is involuntary psychiatric treatment that exists in the community (IPTA, 2015). A person is eligible for a CTO if, due to a mental disorder, they lack the decisional capacity to make treatment decisions, and "…during the immediately preceding two-year period, the person has been detained in a psychiatric facility for a total of sixty days or longer, has been detained in a psychiatric facility on two or more separate occasions, or has previously been the subject of a community treatment order…" (IPTA, 2015, p. 20). A CTO is reviewed every six months by a review board (or sooner if a review is requested by the patient's substitute decision maker) and, if the individual continues to meet criteria for a CTO, it can continue to be reviewed. CTOs are reviewed by the Minister of Health in their sixth year (IPTA, 2015).

The aim of involuntary psychiatric care is to provide mental health care to individuals that due to their psychiatric disorder, lack insight or capacity to make treatment decisions. The goal of laws like IPTA is to provide treatment that provides the least restrictive treatment possible while maintaining self-determination (IPTA, 2015), however, due to the White supremacist ideals upon which the current health care is built, people of the Black diaspora are disproportionately subjected to the harms of the involuntary psychiatric care system. Black Canadians are more likely than White Canadians to be admitted involuntarily during a first-episode of psychosis (Anderson et al., 2014). Higher rates of compulsory admissions for Black people compared to White people has also found in the United Kingdom (Ajnakina et al., 2017; Mann et al., 2014; Morgan et al., 2010; Morgan et al., 2017) and in the Netherlands (van der Post et al., 2012). Once admitted to the hospital, the care that Black people receive differs from their White counterparts.

Studies continue to find that Black people with mental illness receive higher doses of antipsychotic medication for more extended periods than White patients with similar clinical courses (Fleck et al., 2002) and are more likely than their White equivalents to receive long-acting antipsychotic depots (Kuno & Rothbard, 2002). When Black patients receive antipsychotic depots, they are more likely to receive first-generation antipsychotics (Caballero et al., 2023), which have a higher likelihood of detrimental extrapyramidal side effects (Chokhawala & Stevens, 2023). Black people experience higher rates of physical and chemical restraints in emergency department psychiatric evaluation compared to matched White people (Smith et al., 2022) and continue to be diagnosed with nonaffective psychosis at higher rates (Chung et al., 2023). However, nowhere is the burden of being Black and mentally ill seen more powerfully than in involuntary psychiatric care vis-à-vis modern policing. The following vignettes are meant to provide a basis for what Black mentally ill Canadians experience in the news and the possible fate of interacting with police as a Black Canadian with mental illness. The goal of this review is to understand the first-hand stories of Black Nova Scotians and their experience with involuntary psychiatric care, but first, the primary researcher aims to explore the structures within which involuntary psychiatric care is encased, which in part, is modern-day policing.

On June 11, 1996, Wayne Williams, a 24-year-old Toronto man, was shot and killed by police during an exacerbation of schizophrenia (Ontario Ministry of The Solicitor General, 2000). Williams had been receiving treatment on and off for schizophrenia. In the months leading to his death, he was assessed at the emergency room and discharged home. During court proceedings, it was found that the plan for follow-up care after the emergency room assessment was unclear. The coroner gave ten recommendations that could have prevented William's death. These included continued education for police on working with individuals during a mental health crisis, development and training on non-lethal weapons, and increased education for the public on available resources for those with mental health concerns (Ontario Ministry of The Solicitor General, 2000).

On August 29, 2010, Reyal Jardine-Douglas, 25, was shot by police on a Toronto bus. Jardine-Douglas had mental health concerns. His mother had brought him to the hospital for a psychiatric evaluation in the days leading up to his death, but Jardine-Douglas fled the hospital due to paranoia surrounding police. In the hours leading to his death, Jardine-Douglas' sister had called 911 in an attempt to have Jardine-Douglas brought to the hospital involuntarily as she was concerned about the further deterioration of his mental health. Her attempt was not successful, and Jardine-Douglas fled. His disorganized behaviour can be seen in bus footage, where he went from sitting quietly to advancing on officers with a knife. This latter action ended in his death by police (Kane, 2013; Ontario Human Rights Commission, 2017).

In November 2013, Ian Pryce, a 30-year-old Toronto man with schizophrenia, was approached by officers due to a warrant for his arrest (Fraser, 2015). He had been charged with assaulting a security guard at the Centre for Addictions and Mental Health (CAMH) when he attempted to leave the facility (Gillis, 2015). On the night of his death, Pryce fled police who were attempting to take him into custody. He took cover on an apartment building porch, resulting in a standoff with police. Pryce had a pellet gun that he pointed at police. When he stood up, he was shot by two officers. Officers were cleared of charges (Gillis, 2015).
The Mayor and Members of the Toronto City Council posted a condolence motion, acknowledging that a lack of mental health services led to Pryce's death (Toronto, 2013).

On March 20, 2015, police were called to a neighbour dispute after Marc Ekamba, 22 years old, called his neighbours a "witch" and was endorsing other "religious delusions" (Balintec, 2022). Officers fired 19 bullets, 11 striking and killing Ekamba. The responding officers were cleared of charges in Ekamba's death, but the jury gave 35 recommendations (Ontario Office of the Chief Coroner, 2022). Recommendations included ensuring all officers take a four-day mental health training with regular refresher courses and that officers should receive "annual implicit bias and cultural competency training to address stereotyping of Black people, and the existing research on anti-Black racism in policing" (Ontario

Office of the Chief Coroner, 2022).

On July 5, 2015, police responded to a mental health crisis call by Andrew Loku's neighbour in Toronto (Canadian Mental Health Association [CMHA], 2018). Loku, 45, was an immigrant from South Sudan and had post-traumatic stress disorder. He was amid a mental health crisis and had several encounters with police and community members over the hours before his murder. Loku was holding a hammer above his head when police arrived at his home—twenty-one seconds elapsed between the police initially speaking to Loku and when he was fatally shot (CMHA, 2018). Loku's death was ruled a homicide, but no charges were laid in his death (CBC News, 2016).

On July 24, 2016, police were called to an Ottawa coffee shop due to a complaint that a man was causing a disturbance (Thibert, 2020). Somali man Abdirahman Abdi, 37, was known in the community to have mental health concerns. Police arrived on the scene and asked Abdi to leave the coffee shop. Abdi left and subsequently fled. An officer pushed him and hit him several times in the head by officers. Officers continued to strike Abdi several more times, leaving him unconscious. Paramedics were called and, on arrival, started CPR. He was pronounced dead the following day. The responding officers were found not guilty of the death of Abdirahman Abdi (Thibert, 2020).

On June 27, 2017, Pierre Coriolan was shot three times by Montreal police, resulting in his death by abdominal hemorrhage and blunt force trauma (MacLellan, 2022). Police were at Coriolan's residence in response to a mental health crisis call from a neighbour. The coroner report found that police were following outdated protocols, which led to Coriolan's death, and made 16 recommendations to improve police interactions with people in mental distress. However, no criminal charges were laid on the responding officers (MacLellan, 2022).

On the morning of February 23, 2019, police responded to the Winnipeg apartment building of Machuar Madut, a 43-year-old South Sudanese immigrant (Unger, 2020). Machuar, described as "quiet" and "industrious," had expressed recent paranoia, believing that people were following him, and the television was talking to him. On the morning of his death, he was acting bizarrely, using a hammer to knock down apartment doors. Police responded, and a struggle ensued. Police fired shots, resulting in Machuar's death (Unger, 2020).

On November 20, 2019, neighbours called police at the Mississauga home of Clive Mensah, a 30-year-old man, due to Mensah's bizarre behaviour (Nasser, 2021a). Police tasered Mensah, used pepper spray, then handcuffed him. On the ground, he became unresponsive. Another officer arrived on the scene and found that Mensah was facedown with "foam coming from his mouth and no pulse."

> The handcuffs were not removed until a fifth officer arrived. Paramedics were delayed in arriving because the police cars blocked the street (Nasser, 2021a). Although the Special Investigation Unit found that officers used excessive force, no charges have been laid on the responding officers (Nasser, 2021b).
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> On April 6, 2020, D'Andre Campbell, a 26-year-old African Canadian man, called Peel Regional Police, requesting he be taken to the hospital (Nasser, 2020). Campbell had schizophrenia and had called the police on himself in the past to be taken to the hospital. Campbell was known to the local police as they had responded to his home for various mental health concerns in the past (Special Investigation Unit [SIU], 2020a). However, on this occasion, Campbell was fatally shot by the responding officer inside his home after officers found Campbell to have a knife in his hand (reports varied if Campbell had been preparing food or had intended to use the knife as a weapon). No charges were laid in the death of D'Andre Campbell (SIU, 2020a).
>
> On May 27, 2020, police were called to the Toronto apartment of Regis Korchinski-Paquet, a 29-year-old Black-Indigenous woman, due to an ongoing mental health crisis (SIU, 2020b). Korchinski-Paquet was approached by police in her apartment. She went onto her balcony, attempted to escape, and fell to her death. Regis Korchinski-Paquet's death was determined to be accidental, and no charges have been laid (SIU, 2020b).

What the above lives and deaths have in common is that the deceased was a Black Canadian who experienced mental illness. Many of the families of the victims told stories about how they attempted to connect their family members to mental health services in the time leading to their deaths. Another common thread between a number of these deaths was that the individuals were immigrants to Canada. Racialized immigrants are less likely to access mental health care in Canada due to a variety of barriers, such as language and fear of discrimination (Thompson et al., 2015). Many of the people killed in the above stories were young men. Death by police shooting was found to be the leading cause of death for Black men in the United States in 2019 (Edwards et al., 2019). These vignettes serve as the background upon which this study sits: that to be Black and live with a mental illness in Canada is not neutral. Further, these cases demonstrate that the intersection of Blackness and disability (in this case, mental illness), with other factors such as poverty, immigrant status, and non-Christian religion, can be detrimental to one's health within a White-supremacist society, such as Canada.

In the following study, participants' narratives were explored to begin to understand the experience of Black Nova Scotians who have undergone involuntary psychiatric care in this province. Unlike the cases above, the experiences of those in psychiatric care often go untold to the public[3] due to the stigma surrounding serious persistent mental illnesses such as schizophrenia (Marcussen et al., 2019). Inpatient psychiatric care is highly stigmatized (Mathison et al., 2021), particularly in the Black community (Smith et al., 2023). Therefore, significantly muted are the stories of Black Canadians with mental illness. However, it is essential to share these stories as the experience of Black Canadians who have experienced involuntary psychiatric care is underreported in the literature.

Sharing these narratives with the public increases awareness, decreases stigma, and improves outcomes for people with mental illness (Taylor & Kuo, 2019; Thornicroft et al., 2022). Along with the dearth of studies that exist detailing the experience of Black Canadians who have experienced involuntary psychiatric care, there are even fewer about

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[3] Although this author recognizes that there was a time, not that long ago, where the deaths of African Canadians killed by law enforcement would not have been published in a mainstream media.

the Black Nova Scotian experience in this realm. This absence misses out on the unique experience of being Black in Nova Scotia.

Positionality.

The primary researcher of this study has a unique view of the current topic. She benefits from many aspects of privilege. She is a White, settler, cis-gendered woman who was born and raised in Nova Scotia. She is a registered nurse, who, out of nursing school, took a position on an acute psychiatric care unit in Halifax. There the primary researcher witnessed the experiences of people who live with serious persistent mental illness and the realities of being admitted involuntarily. Furthermore, she witnessed differences in the experiences of Black patients, especially in the ways in which they were admitted. For example, she noticed that African Nova Scotian patients were often brought to the emergency department by police rather than directly admitted through by their psychiatrist and noticed that seclusion was used more frequently and with a lower threshold for Black patients. The primary researcher noted that the attitudes of the mostly-White staff towards the Black patients were often accompanied by feelings of not knowing how to best care for clients who were Black and that the experiences of Black patients were further nuanced if the patient was an immigrant, did not speak English as their first language, if the patient was not Christian (specifically if they were Muslim), and if they were young and male. Thus, the idea of this project was born. Through the encouragement of my supervisors, this idea became a fully-fledged project. The observations the primary researcher had made on the acute psychiatric care unit were supported by the histories of people of the African diaspora and the legacies of medical maltreatment.

History of Diverse Black Nova Scotians

The current study aims to explore the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care. The term diverse Black Nova Scotians refers to anyone residing in Nova Scotia who identifies as a person of African descent. This group includes African Nova Scotians, whose heritage can be traced to the Black Loyalist settlers of Nova Scotia. It also includes newer immigrants of the African diaspora who settled in Nova Scotia from the United States, other areas of Canada, and the Caribbean in the early 19th and 20th centuries. This group includes first- and second-generation immigrants from these places as well as African countries like Nigeria or Ethiopia. Also included are Nova Scotians of mixed race, biracial, multiracial, or Afro-Indigenous ancestry. The history of Black people in Nova Scotia begins where the African diaspora begins, in the cradle of humankind, Africa.

African civilization is a complex and diverse set of cultures, including an intricate lineage of linguistics, music, art, and agriculture (Pachai, 2007). Despite this complex and fully formed society, Europeans saw African people as subhuman, considering their culture primitive. European colonizers saw differences in skin, hair, and culture and reported back to European society stories of the superiority of the White race (Pachai, 2007).

Colonialization and White supremacist beliefs set the stage for the transatlantic slave trade (Pachai, 2007). Between 1450 and 1850, African people were subjected to kidnapping and imprisonment into slavery. In the period between 1650 and 1850, 19 to 25 million African people were forcibly removed from their homes and imprisoned in slavery in the Middle East, Europe, North America, South America, and the Caribbean (Pachai, 2007).

People stolen from West Africa accompanied the first French and British settlers of Canada as enslaved people (Pachai, 2007). The first Black person in Canada was said to be Mathieu da Costa, brought to Acadia (now South Shore Nova Scotia) by French settler Governor de Monts in the early 1600s. Slavery was encouraged by King Louis XIV to provide labour to build settlements for the French in Canada. Slavery was not as widespread in Canada as in other areas, such as the United States, due to the climate and nature of the exports from Canada at the time. The primary industry in Canada was the fur trade, and enslaved people were not needed in the same numbers that they were where large-scale agricultural operations were abundant (e.g., sugar in the Caribbean and cotton in the American South). However, enslaved Black people were essential in building many historical landmarks in Nova Scotia, including the Fortress of Louisburg and the Halifax Citadel (Pachai, 2007).

Between 1782 and 1792, 3546 freed Black people, named the Black Loyalists, migrated to Nova Scotia (Pachai, 2007). Some had served for the British Army during the American War of Independence, hoping to receive land in Nova Scotia in exchange for their service. Black Loyalists settled in Nova Scotian communities, including Birchtown, Brindley Town, Little Tracadie, and Preston.

Along with their freedom and the freedom of their families, they were promised parcels of land of 500-600 acres per family and rations for the first three years. However, this was not the case. Food rations were not provided, and housing was in tents and abandoned buildings. The land was not provided for many, and when it was, the size was significantly smaller than was promised (on average, 30 acres were provided). Furthermore, the land provided was unsuitable for farming, often rocky or swampy. The Black Loyalists could use their skilled trades as farmers, woodcutters, and blacksmiths to find paid work, but wages were meagre. Black Loyalists were experiencing horrible living conditions and harsh weather.

These hostile conditions faced by the Black loyalists were further complicated by racial strain from poor White people. The White Nova Scotians were also facing shortages of resources and blamed the Black Loyalists for their disparity. This tension erupted in racial riots in Shelburne on July 26, 1784 (Pachai, 2007).

Life was challenging for the Black Loyalists. Those who survived the first few years experienced frigid weather and inadequate housing and food (Pachai, 2007). They attempted to integrate into the existing churches but were faced with discrimination. Community leaders rallied and started their own congregations, and Baptist and Methodist churches became the heart of the community. The Sierra Leone Company was founded by White European abolitionists who wanted to help Black Loyalists return to Africa, specifically the newly colonized Sierra Leoa (now Sierra Leone). The migration of 1196 Black Loyalists from Halifax to Sierra Leone occurred on January 15, 1792. Many who emigrated were religious leaders and teachers, leaving a gap in the Nova Scotian Black community (Pachai, 2007).

The Black Loyalists were not the only Black migrants to Nova Scotia. Maroon colonies were groups of Black people living in Jamacia and Haiti who maintained independence from slavery through rebel measures (Pachai, 2007). The Trelawny Maroons in Jamacia were able to keep their freedom until 1796, when they were overpowered by White slavers and expelled to Nova Scotia. In Halifax, they were granted freedom in exchange for their labour in rebuilding Citadel Hill. After the completion of this project, they were given land in Preston. The Maroons were not agreeable to their move to Nova Scotia and continued to see themselves as captives (Pachai, 2007). Their opinion of their freedom was based on fact as they had been forcefully relocated to Nova Scotia, had been given rocky and infertile land in Preston, and continued to be subjected to hard labour. They protested their conditions by refusing to work on government projects and only farmed enough to sustain themselves. They were deported to Sierra Leone in 1800 (Pachai, 2007).

Slavery continued in the British Empire, including Canada, until August 1, 1834, when Black people were emancipated under *The Slavery Abolition Act* (Government of Canada, 2022). However, by the time this law came into effect, most Black people had already been emancipated from slavery, either through lack of need of their services, people who escaped bondage through running away, and, in a minority of cases, freedom due to owners’ changing ideas about the ethics of holding a person in bondage (Pachai, 2007). Even though the law saw Black people as freed individuals, the general White public did not see it that way, as evidenced by treatment by the law, the public, and physicians.

Being Black in Nova Scotia is a distinct experience from anywhere else in Canada. The culture of Black Nova Scotia continues to be influenced by ongoing immigration, including a wave of Caribbean migrants who came to Cape Breton to work in the Coal Mines in the 1920s. More recently, ongoing migration from Jamacia and African countries, with the most recent majorities from Ethiopia and Nigeria, has grown in the past decade (Statistics Canada, 2021). Black people from other Canadian provinces, the United States, and the United Kingdom have also made Nova Scotia home. These historic and more recent groups have laid the groundwork for a rich, distinct culture unique to Nova Scotia.

Further to Nova Scotia having the oldest Black legacy, this province has factors contributing to the distinct Nova Scotian experience. Although there is a large Black population in Nova Scotia, communities are relatively isolated from urban centers and services, both geographically, as is the case for Preston-Cherrybrook, or culturally, as is the case for the historic communities of Africville in Halifax and "The Avenue" in Dartmouth (Sehatzadeh, 2008). This isolation has created strong roots and community care and protects from racism and discrimination (Sehatzadeh, 1998; Thomas Bernard & Bonner, 2013). The most insidious examples of anti-black racism and discrimination faced by Black Nova Scotians come from systemic and structural policies and decisions. For example, Nova Scotia was one of Canada's last provinces to have sundown laws (Hamilton-Hinch, 2015; Kakembo, 2020), laws which prohibited Black people to be present in certain towns or counties after sunset, with violators facing arrest or violence (Coen, 2020). Racial segregation in Nova Scotian schools remained law until 1950, with the last segregated school remaining open until 1983 (Henry, 2021). Other histories specific to African Nova Scotians include a shared history of experiences of abuse and neglect at The Home for Colored Children (Council of Parties of the Nova Scotia Home for Colored Children Restorative Inquiry, 2018; Maynard, 2017) and the razing and forceful relocation of the residents of Africville (Nelson, 2008). More recently, the Nova Scotian government has come under fire for race-based street checks and collection of personal data by police (Wortley, 2018), with street checks existing as a standard practice by police towards racialized people up until their ban in 2019.

Another factor contributing to the unique experience of Black Nova Scotians is the unprecedented increase of international immigration to Nova Scotia in the last five years (Nova Scotia, 2023a), with African countries being the second most common place of birth for recent immigrants (Statistics Canada, 2021). This boom has dramatically increased the ethnic and cultural diversity in Nova Scotia. This shift is unlike other areas in Canada, where international immigration of Black people has been more common for a long time (Nova Scotia, 2023b). For African Nova Scotian communities, migration from African and Caribbean countries has, according to Walker (2022) "lend[ed] numerical strength, a new level of professional and occupational status, and leadership and organizational innovation in the media, business, politics, and community affairs" (p. 269) to the indigenous African Nova Scotian communities. This migration has also enhanced connection between African Nova Scotians to the global African diaspora, stimulating political movement in the continue to fight against White supremacy (Walker, 2022). However, for many White Nova Scotians, they are only encountering people of colour and different cultures for the first time in recent years. This experience has been a learning curve for many White Nova Scotians. Although multiculturalism is part of Canada's promise, many Nova Scotians are experiencing what ethnic diversity means for the first time.

Owing to the above factors, the experience of Blackness in Nova Scotia is unique among Black Canadians. However, like other communities within the African Diaspora, the principles of Africentrism play a role in how African Nova Scotians have created their cultural landscape. The values of Africentrism are at odds with the Eurocentric values of the current involuntary psychiatric system. Este and Thomas Bernard (2019) map the four main principles of Africentrism that relate to African Nova Scotians. The first principle is the interconnection of all things, which embraces the idea that human beings are connected to all things in their environments and that relationships with family and community are essential to the sense of self. Interpersonal relationships are necessary in building hope for the future (Este & Thomas Bernard, 2019). The tenent of collective identity, the second Africentrism principle, states that an individual cannot be understood on their own but only in connection to their wider group. Collective identity also prioritizes responsibility for other community members, respect for elders, and the idea of the community, rather than the parents alone raising the community's children (Este & Thomas Bernard, 2019). The third principle is the affective dimension, which stresses the balance and interconnectedness between emotions and rationality and sees emotional experience as essential to understanding someone's experience (Este & Thomas Bernard, 2019). Finally, Este and Thomas Bernard (2019) note spirituality as essential to the Africentrism view. They state that the spiritual nature of human beings is essential for balance. Spirituality, understood through an Africentrism lens, opposes Eurocentric materialism, and when spirituality is expressed, one fully experiences self-worth, peace, value, and purpose (Este & Thomas Bernard, 2019).

Diverse Black Nova Scotians who find themselves within the involuntary psychiatric care system may struggle due to the contradiction of Africentric values and values upheld in the current health system. The current health system, which includes the system of involuntary psychiatric care, places the individual, rather than the family or community, at the center of care. Reason and fact are prioritized over emotion, and spirituality has little to no space in decision-making. Therefore, this author poses that the experience of diverse Black Nova Scotians who have been involved in involuntary psychiatric care is unique compared to other Nova Scotians. Furthermore, people of the African diaspora who have had involuntary psychiatric admissions in Nova Scotia experience care differently from their peers in other parts of Canada due to the unique historical factors in Nova Scotian history and the legacy of forced migration and chattel slavery in North America. Therefore, the objectives of this project are threefold:

1. To explore the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care.
2. To understand the perspectives of Black Nova Scotians about placement under acute involuntary psychiatric admissions and community treatment orders.

3. To explore how experiences of being under involuntarily psychiatric treatment influence diverse Black Nova Scotian people’s interactions with the health care system before, during, and after involuntary psychiatric care.

The main question this project asks: what are the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care? Sub-questions include:

  a. How does involuntary psychiatric care influence trust, help-seeking, and stigma in diverse Black Nova Scotians?
  b. What factors contributed to participants’ placement under involuntary psychiatric care, and what role did family, community and the health system play in this experience?
  c. How do race, migration status, gender identity, sexual orientation, age, ability/disability, and socio-economic status play a role in the process leading to, during, and after involuntary psychiatric care?

CANADA IS SO POLITE by El Jones (2022)

Canada is so polite
It’s like someone bumps into us in the Tim Horton’s line
And we say sorry
We’re always saying sorry
Well, I mean, not to the Indigenous people for stealing their land
And Harper only kind of apologized for residential schools while crossing

the fingers on his hand
And not to Angelique who we hanged
And not to everyone we bombed in
Afghanistan
And not for the internment of the Japanese
Or for the deaths on the railroad built by the
Chinese
And not for breaking the Treaties
Or racist immigration policies
But we're so polite we always say please

Well, not to our migrant workers or
imported nannies
But they should get down on their knees
Because Canada is the Promised Land
No, there was no slavery
Just the Underground Railroad because
Canada is a gravy train
So forget about the ads for runaway slaves
in Halifax newspapers
Canada is a safe haven
For lazy immigrants who come here and we
just give you welfare
Earned by hardworking white taxpayers

Because Canada is so white
Just rosy cheeked white people playing in
the snow and ice
Just snowshoeing and canoeing all day and
night
And okay, those things were taken from
Indigenous people too
But we invented hockey, right?

Oh wait, it was Black people who invented
the slapshot and butterfly
goaltending?
Well, we hide that all out of sight

And that's why Canada is so quiet
Because everyone in Canada is so nice
And let's not mention the Shelburne race
riot
Or cross burnings or Africville
Or 1200 missing and murdered Indigenous
women
But there's no genocide
Shhhhhhhhhhhhhhhhhhhhhhhhh
It's rude to raise your voice in Canada
So let's just smile
Canadians aren't racist, we're peacekeepers,
we're civilized.
And Don Cherry's a national icon
But Canadians aren't violent or bigots, that's
just hockey fights

Canadians are so perky!
No there's no dirty secrets here
Canada is just quirky
Like we say zed and not zee
But if you talk about racism we'll be like,
zzzzzzzzzzz,
There's no need for that here

Canada is never abusive
Canada is so inclusive
Canada is so inclusive, and the proof is
we let other people be here

It's like, I just stole your land and now we're
throwing a party, but you can stand
at the back if you show us ID
It's like, I just put you in the hospital, but
here, let me start you an IV
It's like, what are you complaining for, you
got six weeks of *The Book of
Negroes* on TV
It's like, we're going to hoard all the toys
but we might give you one if you
ask us nicely
We could acknowledge that you have things
to offer us but that's not likely

It's like P.K. Subban
We might let you be on the Olympic hockey
team
If you just stop being so Black –
I mean so cocky
It's not about race, it's about character
We just don't want you to embarrass the
country
It's just your attitude, we're not saying
anything ugly
I mean you should realize you're so lucky

It's not like America here,
There's no history of segregation
That's why we put Canadian flags on our
backpacks when we travel abroad
Because Canada has such a good reputation
Okay, we get to travel, you probably don't
But you just don't know how to teach
English to those Asians
Or build houses in Africa
The country, of course, not the continent

Canadians are so helpful
Because Canada is so tolerant
Which means we know your culture is
worse than ours
But we let you do your primitive things
because Canada is so confident
So confident that we know better than you
Because our way of doing things is just
dominant
We even let you wear your hijab –
Unless it's Quebec –
It's just unfortunate your culture makes you
so oppressed
It's not about racism, it's just about respect
For our shared values

But we like your little costumes!
They're so colourful!
Because Canada is multicultural!
We just wish that all you people of colour
could be more punctual
It's just that white culture is just more
functional
But we just love diversity
And let's forget about how a majority votes
Conservative
It's just amazing that so many different
cultures go to our child's nursery

But then we complain when you get an
affirmative action bursary
Canada's multicultural as long as you put
white people first
We like your food, fun, and fashion but past
that, isn't it kind of like racism in
reverse?
I mean, it's so unfair how Black and Native
people get free university
We just want to make sure that everybody's
worthy

Because Canada has so much courtesy
We speak English and French!
Okay, not perfectly.
Okay, most people only know the French
words for cereals
But let's not be absurd, this is still an
English country
Or haven't you heard?
But there's no distinct societies in Canada

And that's why Canada is so bland
Nothing to see here, just miles upon miles of
stolen Indigenous land
Just fisherman and farmers and maple syrup,
because that's Canada's brand.
Just fields of wheat and outdoor ice rinks in
all thy son's command
There's no guns and violence here, just
socialist health care plans
And just ignore the environmental damage
from the oil sands

Because Canada is so grand
So good at perpetuating this international
scam
So sincere at pretending there's no blood on
our hands
Because Canada's not like that, Canada's
white as a lamb
And those "other" people, they're just so
angry
But true Canadians just don't understand

Chapter 2: Literature Review

The following literature review will start by laying the groundwork of where this study sits by briefly reviewing the structural determinants of health, followed by the legacy of medical maltreatment faced by people of the African diaspora. Next, the status of health and mental health for diverse Black Nova Scotians today will be discussed. The literature about this study's research questions will then be reviewed.

Structural Determinants of Health

Race is a social construct defined by several dimensions, including phenotypical features, self-identity, and others' perception of self (Roth, 2016). Despite being socially constructed, race is one of the main determinants of health (Public Health Agency of Canada, 2020; Mikkonen & Raphael, 2010). The social determinants of health are the external forces that impact a person's health and include income, employment, education, early childhood development, physical environment, social safety net, access to health services, genetics, gender, culture, and race (Public Health Agency of Canada, 2001). By examining the health of these factors, we can predict an individual's health. This upstream approach moves the onus of health away from a purely individualized matter to understanding health as the intersection of social factors. However, the social determinants of health still place a great deal of emphasis on the individual. More recently, scholars are moving further upstream to look at the structural determinants of health (Crear-Perry et al., 2021).

Structures are the tangible aspects of public works, such as food distribution networks, water and waste disposal systems, transportation, and the bureaucratic and oft-invisible forces that make up "common sense" know-how (Metzl & Hansen, 2014). Crear-Perry et al. (2021) define structural determinants of health as the "cultural norms, policies, institutions, and practices that define the distribution (or maldistribution) of social determinants of health" (p. 231). Furthermore, "structure…" states Metzl and Hansen (2014), "…connotes assumptions embedded in language and attitude that serve as rhetorical social conduits for some groups of persons, and as barriers to others" (p. 128). Therefore, even if an individual has adequate social determinants of health (e.g., livable income, safe housing, and education), they still may be denied access to the structures that enable optimal health due to a lack of common-sense know-how denied to their race due to colonialism and racism. Using a structural lens takes the responsibility for poor health away from individual or biological characteristics and places the blame on the structure.

For Black Canadians, inequities in structural determinants of health unfurl as gatekeeping, discrimination, and disadvantage in accessing the structures that lead to health, such as generational wealth, higher education, safe housing, access to green space, quality health care, and access to healthful food compared to White Canadians. One of the main structural forces contributing to the health of Black Canadians is the healthcare system. The health care system and its agents are built on a White supremacist and discriminatory history, evident in the historical and current mistreatment of Black and Indigenous people by the hands of the state.

Medical Maltreatment

In the American South, chattel slavery was the primary source of labour and economic prosperity (Washington, 2006). Despite the importance that Black people had for the economic success of the South, the health of the Black person was not only disregarded but tortured at the hands of the Antebellum physician (Washington, 2006). Enslavers were often reluctant to call costly physicians to tend to the people they held captive, but when they did, Black labourers were often accused of malingering or laziness. Black folks might have fared better if they were not "cared" for by Antebellum physicians. Accounts of treatments provided by these doctors tell of horrendous treatments with no basis in science (Washington, 2006). Enslaved people were used as experimental bodies to test if remedies were safe for White patients. Washington states:

> Southern medicine of the eighteenth and early nineteenth centuries was harsh, ineffective, and experimental by nature. Physicians' memoirs, medical journals, and planters' records all reveal that enslaved black Americans bore the worst abuses of these crudely empirical practices, which countenanced a hazardous degree of ad hoc experimentation in medication, dosages, and even spontaneous surgical experiments in the daily practice among slaves (2006, p. 29).

As medical science progressed, the treatment of enslaved Black people and Freedmen and Freedwomen did not improve. Notoriously, James Marion Sims, known as the "father of gynecology," performed invasive and painful experiments and surgeries on enslaved Black women without their consent and anesthesia (Washington, 2006). He performed dozens of surgeries on each woman, with little care for antiseptic technique or outcome, resulting in high levels of disability and death (Washington, 2006). Dr. Sims continued to be celebrated for his advancements in the field of gynecology up until at least 2011 (Zhang, 2018). The gruesome treatment of Black women by Sims continued into modern medicine. The myth that Black people do not experience pain in the same way as White people and that Black people are tough and strong continued into the 20th century (Washington, 2006).

In Canada, the fate of Black people by the law and at the hands of medical professionals was not much brighter. Black Canadians, along with other racialized people, were segregated from Whites and barred from schools, restaurants, movie theatres, barbershops, hospitals, and neighbourhoods (Henry-Dixon, 2021). For aspiring Black health professionals, the segregation from medical and nursing schools blocked ambitions. A recent article from the University of Toronto totes the achievement of putting up a plaque honouring the first Black physicians in Canada, Alexander Augusta and Anderson Abbott, who graduated from the university in 1860 (University of Toronto, 2023); however, in 1918 the Queen's University senate passed a motion to ban Black students from entering their medical school (Queen's University, 2020). This move by Queen's University led to Black students being dismissed from their program, not regaining entry until 1965 (Queen's University, 2020). Black women were prohibited from training at Canadian nursing schools until the mid-1940s (Flynn, 2009). The first Black nurses to train in a Canadian nursing school were Ruth Bailey and Gyennth Barton, who graduated from the Grace Maternity School of Nursing in Halifax in 1948 (Flynn, 2008) despite the nursing school opening twenty years prior. Restricting the movement of Black Canadians into professional positions not only impacted the socioeconomic status of the aspiring healthcare professionals, but it also impacted the healthcare of Black Canadians who would be forced to be cared for by an all-White medical system for generations.

While researching the history of the healthcare experiences of Black Canadians in the 19th and early 20th centuries, very few results emerged. To the primary researcher, this demonstrates the very Canadian way that the racist treatment of Black Canadians has been hidden and normalized. It also reveals to the primary researcher that harm against Black Canadians were commonplace and legal, and therefore, only now, in the last few decades, are coming to light. Thornhill (2008) states that the legal history of Canada has played an "…enabling role of accommodation that law has consistently played throughout history in the subordination of peoples of African descent. It is a role of *collusion* with race that more often than not has aided and abetted racism and racial discrimination" (p. 322). Therefore, despite practices such as segregation being legal, it legitimized racism and subservience of Black and racialized people in Canada in everyday life, including the quality of health care for Black Canadians.

Even though chattel slavery was not as widespread in Canada as it was in the United States, Black people, both freed and enslaved, experienced overt discrimination and racism in Canada into the 20th century (Manyard, 2017). For enslaved Black Canadians, conditions such as poor housing, poor or absent health care, and disregard for freedom were evident. For freed Black Canadians, discrimination existed in the form of employment, housing, and health care discrimination. For both groups, overt violence was a part of everyday life, and violence was often at the hands of the state (Manyard, 2017). Regardless of the perpetrator, Black Canadians who brought a crime to authorities were denied access to legal charges. Black Canadians were highly surveilled, but no protection came from the agents who watched them (Maynard, 2017). The overt and sublet racism through these structures continue into the present day through the structural determinants of health, which impact the health and mental health status of Black Canadians today (Clark et al., 2022).

Health Status of Black North Americans

For people of the African diaspora, the legacy of medical maltreatment is evident in the poorer health statuses compared to other ethnicities, especially compared to White North Americans. For example, Black Canadians and Americans are at higher risk of developing chronic conditions, such as rheumatoid arthritis (Ciofoaia et al., 2022), neurological diseases (stroke, epilepsy, Parkinson's disease, dementia, headaches, multiple sclerosis, and muscular dystrophy) (Robbins et al., 2022), circulatory (Kisely et al., 2008) and cardiovascular disease (Veenstra, 2019; Parry et al., 2023), and diabetes (Kisely et al., 2008; Public Health Agency of Canada, 2020). When diagnosed with these conditions, Black North Americans are less likely to be offered treatments (Goodman et al., 2016), have less access to culturally relevant information and treatment (Swaleh et al., 2021), and have worse outcomes for chronic conditions (Robbins et al., 2022). Veenstra (2019) found that Black Canadians self-report worse overall health when compared to white and mixed-race matched participants.

Black Canadians and Americans have higher rates of kidney disease than other groups, with disease progression that is more rapid and more progressed at the time of diagnosis (Parekh et al., 2022). Part of this is using a race-based correction for the glomerular filtration rate (GFR) calculation, which has been widely used in North America until recently. The race correction for GFR is unnecessary and, in fact, harmful as there is no biological difference at the basis of this calculation (Inker et al., 2021). The use of the race-corrected GFR measure has resulted in skewed kidney function tests for Black people, showing that their kidneys are performing better than they are, which may delay treatment for chronic kidney disease (Parekh et al., 2022). Further, Black North Americans are less likely to have home dialysis (Parekh et al., 2022) and have less knowledge about the possibilities and benefits of renal transplants (Hamid et al., 2023). Although some research suggests that Black Canadians have lower rates of cancer than White Canadians (Cénat et al., 2022), how Black Canadians and Americans experience cancer are different. Cénat et al. (2022) conducted a scoping review of all cancer research regarding African Canadians and found differences in screening and treatment for cancer across ethnicities. They found that screening measures for cervical cancer were reduced in African Canadian folks, and Black Albertans were less likely to be screened for colorectal cancer than White Albertans. Black Ontario men who identified as gay or at high risk for HIV were less likely to be screened for anal cancer than their White counterparts. When diagnosed with cancer, Black Canadians were less likely to receive supportive care and more likely to receive aggressive care (Cénat et al., 2022).

Black women in America experience higher birth complications, including death, than other ethnicities (Adebayo et al., 2022). In a qualitative analysis of their birth stories, Black women shared that they were given inadequate pain control, felt unable to express choices concerning their pregnancy and birth plans, and felt discriminated against based on race and class (Adebayo et al., 2022). New incidents of human immunodeficiency virus (HIV) are overrepresented in the African Canadian population

(Etowa et al., 2022). Despite 39% of women living with HIV being in the Greater Toronto Area, Medeiros et al. (2022) found that this group has lower viral suppression compared to the rest of Canada. African Canadians with HIV are often in later stages before seeking treatment (Etowa et al., 2022). Disease stigma and fear of the health system were barriers to earlier testing. Lack of culturally relevant information about pre-exposure prophylaxis (PrEP), HIV, and HIV testing in the African Canadian community were also barriers to prophylaxis, diagnoses, and treatment (Etowa et al., 2022).

The COVID-19 pandemic uniquely impacted Canadian Black communities, with this group experiencing higher rates of infection, complications, and death (Lockhart & Nur, 2020). However, exact rates are unknown due to the lack of disaggregated race-based data (Thompson et al., 2021). Black Canadian respondents in Kemei et al.'s (2023) study reported that misinformation about COVID-19 and the vaccines, lack of culturally appropriate resources, anti-Black discrimination about COVID-19 spread, and vaccine hesitancy based on historical mistreatment by the medical system negatively impacted their experiences during the pandemic. Furthermore, Black Canadians work more often in front-line positions that do not allow working from home or missed days due to illness (Etowa et al., 2020). These factors, combined with complicating underlying chronic conditions and socioeconomic factors like the availability of testing sites, created a disadvantage in the identification of COVID-19 for Black Canadians (Etwoa et al., 2020).

The intersection of immigration and race lead to a distinct experience of health. The healthy immigrant effect refers to the trend that the overall health of newly immigrated Canadians is better than the health of the general native-born population, but immigrant health decreases the longer they spend in Canada, with immigrant health eventually deteriorating to worse than that of native-born Canadians (Newbold & Danforth, 2003). This effect is particularly true for racialized immigrants compared to White immigrants. Racialized immigrants are more likely to have hypertension (Patterson & Veenstra, 2016) and type 2 diabetes mellitus (Adjei et al., 2020) than White immigrants. The rates of breast cancer are higher in Black immigrant women in Canada, with this group having longer diagnostic intervals than Canadian-born women (Lofters et al., 2019). Despite having the highest screening rates of immigrant women (Vahabi et al., 2016), Caribbean immigrant women were less likely to have a screen-detected breast cancer result, had longer intervals between detection and diagnosis, and were diagnosed at later stages of cancer than Canada-born women (Lofters et al., 2019).

As reviewed in the above literature, the history of medical maltreatment of the people of the African diaspora and the structural determinants of health impact the physical health status of this group. Intertwined with physical health is mental health, which is discussed below.

The Current Study

The study at hand recognizes the poignant history of Black Canadians and, through this project, aims to explore the experience of diverse Black Nova Scotians who have experienced involuntary psychiatric care. As stated previously, a variety of factors are of interest to try to understand the experience of Black Nova Scotians who have experienced involuntary psychiatric care. These include trust, help-seeking, stigma, and the role of family, community, and the health system. An intersectional lens has been used when presenting the literature, highlighting the role that race, migration status, gender identity, sexual orientation, age, ability/disability, and socio-economic status play in the process leading to, during, and after involuntary psychiatric care.

Trust, Help-Seeking, and Stigma

The first question that the primary researcher hopes to answer is how involuntary psychiatric care influences trust, help-seeking, and stigma in diverse Black Nova Scotians. Help-seeking, trust, and stigma are essential to consider in understanding how people of the African diaspora experience involuntary psychiatric care. These three concepts are intertwined, bidirectionally influencing each other, determining if, when, and how Black people experience involuntary psychiatric care. What follows is a discussion of these three concepts and their role in Black Nova Scotians' experience of involuntary psychiatric care. First, each term will be operationalized, with the discussion moving to share the current literature on help-seeking, trust, and stigma.
Finally, the literature on the interconnection of help-seeking, trust, and stigma will be shared.

Trust and stigma are two common reasons why Black people in Canada and elsewhere are reluctant to seek help for mental health concerns. Taylor et al. (2023) conducted a synthetic review of the research on trust since 1970. They found in multiple studies that Black Canadians cite a lack of trust in the health care system as a barrier to help-seeking (Taylor et al., 2023). Within the concept of trust, a lack of racialized professions and a lack of culturally safe mental health care result in decreased help-seeking for Black Canadians (Waldron et al., 2023). Stigma influences seeking help for mental health problems for Black people.

Factors connected to stigma include the stigma within the Black community about mental health and seeking formal mental support and fear about the ramifications of becoming involved in the mental health care system (Harris et al., 2020). The following section will elaborate on these concepts by presenting the current literature.

The first reason why Black people with mental health concerns may be reluctant to seek help is because of a lack of trust in the health care system. Trust is the "firm belief in the reliability, truth, or ability of someone or something; confidence or faith in a person or thing, or in an attribute of a person or thing" (Oxford University Press, 2023). Trust, and its role in healthcare, is both an input and an output factor for help-seeking; a patient's trust in providers and the system determines how they ask for help, and how providers and the system deliver care also influences outcome measures of trust (Taylor et al., 2023).

Taylor et al. (2023) reviewed the literature on trust in health care from the 1970s to the present day. Of the racial differences between Black and White North Americans, they state that although between-group differences in trust have been found in the literature, the results should not be equated with a biological basis of race. Mistrust of the health care system by Black people is often toted a racial difference in the literature (Boyd et al., 2020). However, differences in how racial groups trust healthcare professionals are more correctly linked to the amount of discrimination that an individual experiences rather than a racially intrinsic trait. The reason that people of the African diaspora have been found to trust healthcare providers less than White people is due to racism and structural inequities, not a biological difference (Boyd et al., 2020; Taylor et al., 2023). The current study understands the concept of trust in this way – a socially constructed concept that develops because of experiences within the health care system rather than an independent trait specific to one racial or ethnic group.

Mistrust of the medical system is logical based on the horrific history of medical experimentation on Black patients and enslaved people. The legacy of medical horrors today has led to tropes within the Black community that Black people do not go to the doctor and believe in "conspiracy theories" about the government and health conditions. However, in hindsight, many of these misgivings regarding formal health care and the agencies that provide healthcare are true. These experiences, although historical, translate into delayed help-seeking for Black Canadians and Americans. For Black men, visits to the family doctor may be less frequent, especially for those who have higher rates of mistrust in the medical system and those who experience higher levels of everyday racism (Powell et al., 2019). These two factors interact to create longer delays in preventative screening tests like blood pressure (Powell et al., 2019).

Another concept related to trust that is a barrier to seeking help for mental health concerns is the lack of racialized mental health care professionals. In a study with African Nova Scotian youth with psychosis, the lack of Black or other racialized professionals was found to interfere with help-seeking (Waldron et al., 2023). All healthcare professionals should be trained to provide culturally safe care regardless of race or ethnicity. Although strides have been made to increase cultural and structural competency in healthcare professionals, culturally competent care is not always available.

Black Nova Scotian women stated that they could not always find mental health care professionals who understood the intersection of race, gender, sexual orientation, and other held identities (Waldron, 2020). Research has shown that Black people with a psychiatric diagnosis feel more mistrust towards mental health staff and services than White or Hispanic people (Henderson et al., 2015). It has also been demonstrated that feelings of mistrust from the Black community were not influenced by involuntary admission, severity of symptoms, or diagnosis. Therefore, the authors conclude that mistrust of the mental health system is related to higher levels of racial discrimination and unfair treatment experienced by Black and mixed-race psychiatric patients (Henderson et al., 2015).

Black Nova Scotian youth with psychosis stated that past experiences of feeling dismissed by professionals when they sought out help deterred future help-seeking (Waldron et al., 2023). African American women interviewed by Woods-Goscombe et al. (2016) expressed feeling like therapy is not "for us." Decreased help-seeking due to a lack of access to Black mental health professionals and past experiences being dismissed by mental health care professionals was mirrored in other studies, including a study with African American women in California (Woods-Giscombe et al., 2016). For many people of the African diaspora, self-reliance and internal strength are essential values, but these values influence help-seeking behaviours. Waldron et al. (2023) found that for African Nova Scotian youth who have experienced psychosis, values of strength and self-reliance interfered with disclosing the need for help.

Sociologist Edwin Goffman (1961, 1963) wrote about stigma in psychiatric institutions and the wider society. He conceptualized stigma as a characteristic of a person that "discredits" them (Goffman, 1963), leading this person to lose credibility or respect. Ways that this could occur, stated Goffman, were through revulsions of the body (i.e., physical differences), the character (i.e., mental illness, sexual orientation, employment status), or of tribe (i.e., race, ethnicity, religion). However, Goffman clarifies that these discrediting characteristics are only stigmatizing within an interaction in which the trait is seen as abnormal or disadvantageous. Within an environment where these characteristics are seen as usual or are accepted, stigmatization does not occur (Goffman, 1963). Link and Phlen (2001) conceptualize stigma in five realms: labelling human differences, linking these labels to undesirable characteristics to create stereotypes, and using labels and stereotypes to separate "us" from "them," which results in a status loss in social hierarchies and individual and/or structural discrimination. Like Goffman, Link and Phlen (2001) state that stigma does not exist independently but must be contingent on power differentials to exist. This point is salient in the conversation of race, mental illness, and involuntary psychiatric care, as perceived power, or lack thereof, is central to this discussion.

In the 60-year history of research on stigma, many sub-areas have emerged to explain the facets of this complex phenomenon. The variants that are relevant to the discussion of stigma, trust, and help-seeking in Black Nova Scotians who have experienced involuntary psychiatric care include perceived stigma, enacted stigma, self-stigma, and structural stigma. Perceived stigma is the public agreement that discrimination exists against a particular group, regardless of agreement with the stereotyped beliefs (Martin, 2015). Endorsed stigma is when the person surveyed believes and enacts the discriminating belief. Like perceived stigma, endorsed stigma can come from the person enacting the stigma or the person receiving the stigma. Self-stigma is when the member of the stigmatized group believes they are lesser based on a discreditable characteristic. Structural stigma refers to governmental or institutional policies that discriminate against a specific group, leading to negative consequences for this group (Martin, 2015).

Stigma has health implications. For African, Caribbean, and Black Canadians, the history of forced migration, educational, social, residential, and vocational discrimination and segregation contribute to race-based stereotypes and stigma for these groups (Public Health Agency of Canada, 2020). Stigma leads to violence against and exclusion of Black Canadians. Stigma influences the structural determinants of health for Black Canadians. Unsafe housing, education barriers, inadequate or unsafe employment, food insecurity, social isolation, risk for violence, and avoidance or reduction of seeking health care services are outcomes of stigma for Black Canadians. Due to racism and stigma, services received by African, Caribbean, and Black Canadians may be of poorer quality, leading to poorer physical and mental health (Public Health Agency of Canada, 2020).

Stigma about mental illness is present in the African Nova Scotian community. Waldron et al. (2023) found that African Nova Scotian youth who have experienced psychosis felt that those with a mental illness would be labelled as "crazy or weak" (p. 203). Alang (2019) conducted a mixed methods study, examining quantitative data from the National Survey on Drug Use and Health Participants, and identified African

Americans who responded that they had an unmet mental health need. She surveyed respondents as to why they identified that their mental health needs went unaddressed. She then conducted focus groups with African Americans asking the same questions. Respondents in Alang's (2019) study spoke about the fear of "double discrimination," that by seeking mental health support, they would experience stigma for their Blackness *and* their mental illness. The fear of experiencing racism and stigma led African Americans to avoid seeking formal support for mental health concerns (Alang, 2019). African and Caribbean migrant people living in the United Kingdom reported that sigma interferes with help-seeking for mental health concerns (Mantovani et al., 2017). A pastor who is an African immigrant living in the UK stated that it is sometimes difficult to differentiate between spiritual needs and mental health concerns, leading to a reinforced stigma of mental illness (Mantovani et al., 2017). Aden et al. (2020) held community focus groups for African, Caribbean, and Black people living in Ottawa to understand their views and experiences with mental illness. The majority of respondents had negative views of mental illness and felt that seeking help for a mental illness was a sign of personal shortcomings.

Mantovani et al. (2017) spoke with members of African-descended faith communities in the United Kingdom. Respondents from African and Caribbean countries often viewed mental illness as a curse related to the devil or as abnormal behaviour. There was a view that mental illness is weakness, in opposition to the belief that African-descended people are strong and that weakness is associated with a lack of faith in God or a moral failing.

Mantovani et al. (2017) conducted semi-structured interviews with twenty-six Londoners of African and Caribbean descent who were active in faith-based organizations. The researchers found that respondents from African and Caribbean countries who have a mental illness that their family's beliefs about mental illness caused alienation between them and their family. Further, participants reported that having a mental illness reflects poorly on the family, thus they were reluctant to be open about their illness due to fear of damaging their family's reputation (Mantovani et al., 2017). Alang (2019) found that younger participants with higher levels of educational attainment were more likely to cite stigma as a reason for not seeking mental health care. African Nova Scotian youth with psychosis surveyed by Waldron et al. (2023) endorsed that mental illness was not commonly discussed in their community, and denial of the existence of mental illness in the African Nova Scotian community was common.

Gender is a factor in how people of the African diaspora seek help for mental health concerns. Black men reported feeling invisible in the health care setting (Alang, 2019). In focus group studies, Black men reported that micro-aggressions, such as lack of eye contact from the provider or assuming that their father was not present in their lives, led to participants feeling disrespected and, in turn, avoiding further mental health care. Participants noted that feeling invisible in the healthcare system contradicted the hypervisibility experienced in the public sphere (Alang, 2019).

Powell et al. (2016) found that African American men who scored higher for ratings on masculinity norms scales and scored higher on experiences of everyday racism expressed higher barriers to seeking help for health concerns. This relationship was mediated by a sense of control, in which African American men who feel they have less control over their lives had more barriers to help-seeking behaviour. Of their results, Powell et al. (2016) explain that African American men may be attempting to regain a sense of control when confronted by racism and threats to social identity. Black men who experience mental illness voiced that they are reluctant to share their diagnosis with friends or a partner due to stigma and stereotypes about Black masculinity (Aden et al., 2020). Alang (2016) found that Black American men were reluctant to admit symptoms of depression because of the contradiction from normative masculinity; to experience sadness, reported one of the male participants, would lead to feeling disappointed in oneself for expressing emotional vulnerability.

Black women also experience barriers to seeking help for their mental illness, mediated by stigma. A review by Taylor and Richards (2019) of the experience of young Black Canadian women of Caribbean descent highlighted the barriers that this group faces when wanting to seek mental health care. The authors state that members of this group cite stigma, racism, sexism, and ageism as obstacles to seeking mental health care (Taylor & Richards, 2019). In their report on stigma, The Public Health Agency of Canada (2020) held discussion groups with Canadians about the impacts of stigma on health. One report quote shows the intersection of gender, stigma, and race. A participant in the discussion group stated, "We're kind of scared, when I say "we're" I'm speaking as a Black woman, we fear not being understood, and most times…I find it more manageable for me to just handle it on my own, or to maybe seek out a friend or family. Where really, I should feel comfortable to go and seek help in these facilities" (p.

34).

When exploring unmet mental health needs of Black Americans, a Black American woman told Alang (2019) that she does not have the "luxury to sit in a therapy chair" while also taking care of her family and her business and "having the weight of the world on [her] shoulders…" (p. 351). Other studies found that women rated high on the Black Superwoman Schema were concerned about the consequences of fully expressing emotions, fear of vulnerability with a stranger, and the burden of other caregiving roles on their time (Woods-Giscombe et al., 2016).

The most stigmatized mentally ill are those with severe and persistent mental illness (Hoftman, 2016). Higher levels of the self-perceived stigma of one's psychiatric disorder are significantly linked with longer durations of untreated psychosis, more severe symptoms of psychosis, decreased psychosocial functioning, lower perceived wellbeing and recovery, and higher rates of depression (Mueser et al., 2020). Gabbidon et al. (2014) surveyed participants in the UK with SPMI on their experiences with stigma. Overall, Black participants rated experiences of discrimination higher than White participants, with people of Caribbean descent noting significantly higher rates of discrimination than immigrants from African countries (Gabbidon et al., 2014). Stigma interferes with occupational success. Mantovani et al. (2017) found that for African immigrants living in the United Kingdom, experiencing mental illness results in self-stigma and limiting beliefs about one's ability to achieve occupational success. This group also reported that self-stigma interacted with discrimination from their employers of what it means to be an employee who has a mental illness (Mantovani et al., 2017).

One of the barriers to help-seeking for African Nova Scotian youth who had experienced psychosis included fear that the police would be involved and that mental health issues would be addressed through negative police interactions rather than through mental health services (Waldon et al., 2023). Moreover, to some degree, this is reflected in the literature. Anderson et al. (2014) found that Black Canadians experiencing their first episode of psychosis were two times more likely to have police involvement in the pathway to care than White Canadians. Alang (2019) found that mistrust in the mental health system led to unmet needs for Black Americans. Focus group respondents stated that fear of being hospitalized impeded their desire to engage in the mental health system. Participants cited that mistreatment by other organizations, such as the foster care system and Black American's historical experiences (i.e., institutionalization, unethical experimentation) with the health care system led to mistrust in the mental health care system (Alang, 2019).

For Black women, seeking help for mental health concerns is sometimes hindered by the "strong Black woman" role (Etowa et al., 2017) or the "superwoman schema" (Woods-Giscombe et al., 2016). These concepts are relevant because although leaning into this image allows Black women to persevere and to be a "pillar of her community, family, and church…" (Etowa et al., 2017, p. 384), it can also lead to isolation, stress, and burnout. A Black Nova Scotian woman was quoted by Etowa et al. (2017) as saying, "I'm tired of being strong… I'm a human being… I'm falling apart…I need to feel human. I don't want to be strong anymore" (p. 287). Woods-Giscombe et al. (2016) found several views and behaviours that are a part of the superwoman schema but lead to decreased formal help-seeking for mental health concerns, including putting faith in God instead.

For people of the African diaspora, family and community are essential players in help-seeking. Rotenberg et al. (2017) found that in Toronto, Black Caribbean and Black African individuals live in areas with higher ethnic concentration, meaning a community has a higher concentration of immigrants and self-identify as a visible minority. They found that those living in areas of higher ethnic concentration are more likely to be accompanied by a family member or friend when coming to the emergency department (Rotenberg et al., 2017). This result demonstrates the essential nature of connectedness with family and community in seeking help for mental health concerns.

For those experiencing symptoms of psychosis and mania, voluntary help-seeking is removed as involuntary laws and treatment come into play. For Black Canadians, the tolerance for these types of mental health symptoms is lower than for White Canadians. In a review of the duration of untreated psychosis, Schoer et al. (2019) found that participants of African origin had a shorter duration of untreated psychosis (DUP) than white participants. Caribbean participants were found to have longer DUP and longer treatment delays than white participants (Schoer et al., 2019). However, they also found that Black Caribbean people waited longer to contact medical professionals after the development of psychosis symptoms (Schoer et al., 2019). Delays in seeking help for a mental health concern can have serious consequences. Folks with evolving mental health concerns, like psychosis or mania, often come to the attention of emergency or crisis services due to the symptoms associated with these disorders.

An important aspect to understand for this study is how involvement in involuntary psychiatric services influences help-seeking, trust, and stigma. Mfoafo-M'Carthy (2014) spoke to twenty-four racialized individuals in Toronto who had been under a Community Treatment Order (CTO). Under a CTO, participants stated that they experienced support from the treatment team, felt that a CTO kept them organized on their path to recovery, and felt that the CTO allowed them to develop strong therapeutic relationships with their treatment team. Racialized Canadians who are under CTOs also voiced that they experience stigma due to their involvement in involuntary treatment in the community. Individuals interviewed by Mfoafo-M'Carthy (2014) expressed that they felt that they were placed under a CTO for reasons relating to their ethnicity, stating that the majority of folks on a CTO are racialized. They stated that being on a CTO caused additional stigma. They noted feelings of coercion about being on a CTO. One participant said that she risked losing her child if they did not comply. Others worried about being detained in the hospital or arrested if they did not comply with the CTO (Mfoafo-M'Carthy, 2014).

Ferrari et al. (2015) interviewed Canadian youth of European-, African- and Caribbean origin who had experienced an episode of psychosis. They found that European youth internalized stigma as shame around their psychosis symptoms. The youth of African origin expressed stigma as self-blame and personal failure to control psychosis symptoms, and youth of Caribbean origin saw mental illness as personal fallibility, but themes of religion were prevalent (Ferrari et al., 2015).

Just because it does not occur within the formal mental health care system does not mean that help-seeking does not exist in other realms. For Black Canadians, formal mental health care alone, as the system currently stands, is not enough to ensure optimal mental health[4]. The church and community are essential help-seeking hubs for Black Canadians when dealing with mental health concerns. Spirituality is essential for African Nova Scotian women (Beagan et al., 2011). Ward et al. (2014) found that participants endorsed coping through professional help, informal support, and religious coping. Those with lower incomes sought religious coping significantly more often than other participants (Ward et al., 2014). Hays and Lincoln (2017) found that in a sample of African Americans with mental illness, the majority of respondents preferred informal support for their illness. Informal support included consultation with family, friends, general practitioners, and clergy.

For Black British people, the church is a rallying point for coming together to support an individual with mental health concerns, sometimes instead of seeking help from formal mental health professionals (Mantovani et al., 2017). In African-based faith organizations, prayer might be used as a substitute for formal mental health treatment, based on the belief that the impacted individual needs exorcism or spiritual intervention to rid them of their symptoms (Mantovani et al., 2017). When Caribbean immigrants in Montreal were asked about recovery, they expressed similar experiences to Euro-Canadians, with the significant difference being the role of religion and spirituality

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[4] It is the case for all Canadians that the mental health care system alone cannot provide all one needs to achieve optimal mental health, but especially for Black Canadians, supplemental care is needed as the current mental health care system is designed to meet the needs of White Canadians.

(Whitley, 2016). Of 47 Caribbean-Canadian people with SPMI interviewed, all stated that spirituality was important in recovery and noted that prayer, church community, and reading religious texts were necessary for comfort and recovery (Whitley, 2016). Despite barriers to mental wellbeing that stem back through slavery, Black Canadians find ways to thrive. Native-born and migrant Black people living in Ottawa have several protective factors that buffer against mental illness (Aden et al., 2020). Some factors included staying active, family support, finding community belonging, supportive healthcare providers, secure employment, safe housing, and access to culturally sensitive services (Aden, 2020).

African Nova Scotian youth who had psychosis felt that education about mental illness and psychosis should be delivered digitality through social media or through an app coming from people who looked like them (young, Black) delivering the information (Waldron et al., 2023). Family members and community leaders emphasized the importance of delivering information about mental illness within the community, by community members who are also professionals in the mental health field to increase knowledge and hopefully increase help-seeking and reduce stigma (Waldon et al., 2023). African American women experiencing depression and anxiety are open to using mobile technology to receive mental health care (McCall et al., 2023; McCall et al., 2022).

Robinson et al. (2018) explored the necessary role of the Black Church in increasing help-seeking in Black men. They gave several suggestions on how to improve Black men's help-seeking, including encouraging the church to overcome the taboo and confront the reality of men's mental health issues targeting youth and elderly congregation members. These types of interventions would be essential when working with Black men with high levels of held masculine norms, as Powell et al. (2016) found that Black men's masculinity norms were barriers to help-seeking. They also found that experiences of racism interfered with help-seeking (Powell et al., 2016). Therefore, it would be essential for the church to continue to work with community members to reduce this stress.

The Roles of Family, Community, and the Health System

The second question this author hopes to address is the roles family, community, and the health system play in the experience of being placed under involuntary psychiatric care. From the voices of African Nova Scotians, spirituality is a culturally significant factor as a part of one's health and as a way of coping with discrimination and life's challenges (Este & Thomas Bernard, 2019). The impact of spirituality and the community it provides, cannot be understated, as historically and presently, African Nova Scotians report that it is through spirituality and connections with the Church and the community they have coped with broken promises, first from the British, who promised fertile land plots to the Black Loyalists. Spirituality has continued to offer a way to survive ongoing racism and exclusion, as well as acting as a tool of resistance. The Black Church also provides a "sanctuary" from the world's woes, a place to connect with a higher power, and a connection to the community's social, political, and educational aspects (Este & Thomas Bernard, 2019). Although the Church as the center of the community is not unique to African Nova Scotians, but it is essential to understand the Church's role to start understanding the culture of African Nova Scotians.

Many in the Black Nova Scotian community understand and experience mental illness in a distinct way. Spirituality is essential for African Nova Scotian women coping with stress (Beagan et al., 2012). Another way of coping for Black women is the "strong Black woman" concept (Etowa et al., 2017; Jefferies, 2022). This concept is relevant because although leaning into this image allows Black women to persevere and to be a "pillar of her community, family, and church…" (Etowa et al., 2017, p. 384), it can also lead to isolation, stress, and burnout. A Black Nova Scotian woman was quoted by Etowa et al. (2017) as saying, "I'm tired of being strong… I'm a human being… I'm falling apart…I need to feel human. I don't want to be strong anymore" (p. 287).

For Black men, spirituality is important for coping and mental health (Robinson et al., 2018), but Black men who experience mental illness voiced that they are reluctant to share their diagnosis with friends or a partner due to stigma and stereotypes about Black masculinity (Aden et al., 2020). Black people, but especially Black men, have been the target of police surveillance and violence (Maynard, 2017; Waldron, 2020). For all Black Canadians, the impacts of anti-Black police violence have lasting impacts on this population's mental health (Waldron, 2020).

DeSouza et al. (2021) provided commentary on the impact that Church closures secondary to the COVID-19 pandemic had on the mental health of older African Americans. The authors, as Black religious leaders and physicians, share how the Black Church serves as a reprieve from the struggles of the racist outside world and how services provide catharsis and connection with God and community members. The authors have observed that church closures during COVID-19 hurt the mental health of older African Americans. Further, many Black churches are underfunded and do not have the technology to broadcast their services via the Internet. If they can broadcast, many older folks experienced barriers in accessing online church services.

Despite barriers to mental wellbeing that stem back through slavery, Black Canadians find ways to thrive. Native-born and migrant Black people living in Ottawa have several protective factors that buffer against mental illness (Aden et al., 2020). Some factors included staying active, family support, finding community belonging, supportive health care providers, secure employment, safe housing, and access to culturally sensitive services (Aden, 2020). However strong these protective factors, mental illness continues to impact the Black Canadian and Nova Scotian communities disproportionately.

Involuntary admission to psychiatric facilities can exacerbate the structural challenges faced by Black Canadian families. Recent Canadian research sheds light on the importance of familial support and cultural understanding in coping with schizophrenia and involuntary admission.

A study by Johnson et al. (2021) explored the experiences of Black Canadian families navigating the mental healthcare system. The findings underscored the critical role of family support in coping with schizophrenia. Participants emphasized the importance of familial bonds, spirituality, and cultural identity in providing emotional and practical support for individuals with schizophrenia. The study highlighted the need for healthcare providers to recognize and respect Black families' cultural values and beliefs to facilitate effective treatment outcomes.

Involuntary admission to psychiatric facilities can strain familial relationships and exacerbate feelings of stigma and isolation. Canadian research by Smith et al. (2020) examined the impact of involuntary psychiatric hospitalization on family relationships within the Black community. The study found that involuntary admission often led to feelings of guilt, shame, and mistrust within families. However, participants also identified resilience and a sense of duty towards supporting their loved ones through recovery. The findings underscored the importance of open communication, education, and community support in mitigating the negative consequences of involuntary admission on Black families (Smith et al., 2020).

Cultural humility and sensitivity within the mental healthcare system are essential for ensuring positive outcomes for Black individuals with schizophrenia and their families. A study by Cénat et al. (2024) emphasized the need for culturally tailored interventions to address the unique needs and experiences of Black Canadians living with psychosis. The findings highlighted the importance of incorporating cultural values, working with community agencies, and integrating anti-racist care into treatment approaches to promote engagement and adherence to care.

The family members of African Canadians are essential for coping and encouraging help-seeking for those experiencing involuntary admission in Canada. Research highlights the significance of familial support, cultural understanding, and community engagement in promoting resilience and recovery. Culturally competent mental health services are essential for addressing the unique needs and challenges faced by Black individuals and their families living with mental illness.

In summary, the current study aims to delve into the multifaceted narratives of diverse Black Nova Scotians who have undergone involuntary psychiatric care. By centring the experiences of this group, the primary researcher seeks to shed light on the intersecting factors influencing their encounters with mental health systems. Through qualitative interviews and narrative analysis, the study will explore the nuanced perspectives of individuals from various backgrounds, including those shaped by race, ethnicity, gender identity, sexual orientation, migration status, socioeconomic factors, age, and disability. By examining the lived experiences of Black Nova Scotians within the context of involuntary psychiatric care, the study endeavors to uncover underlying themes such as trust, stigma, help-seeking, and the role of community. Through this exploration, the researcher aims to contribute to a deeper understanding of the challenges and barriers faced by Black individuals in accessing equitable mental healthcare services.

Chapter 3: Theoretical Framework

The following chapter will outline the theoretical frameworks which will inform the current research study. Minority Stress Theory will be the leading theory that will support this research. By using Minority Stress Theory, the stories of Black Nova Scotians who have experienced involuntary psychiatric care will be understood through the real-life stressors that they experience due to held identities. Identities that will be considered include race, migration status, gender, sexual orientation, age, ability/disability, and socioeconomic status. This study will also use an Intersectional Framework as the foundation upon which Minority Stress Theory sits. Through Intersectionality, the primary researcher will consider how the participants in this study experience and understand involuntary psychiatric care through the intersections of various held identities. Finally, narrative methodology will be discussed. The above theory and frameworks will be described in detail in the following paragraphs, and an argument will be put forth exploring how these ideas will support the proposed research.

Minority Stress Theory

Minority Stress Theory states that minorities experience health disparities at higher rates due to their experiences of unique prejudice-based stressors compared to members of majority groups (Meyer, 1993). Through minority stress theory, the unique experiences of Black Nova Scotians who have experienced involuntary psychiatric care can be understood as part of a response to cumulative and chronic stress resulting from discrimination due to membership of minority identity.

Meyer (1993) developed the Minority Stress Model to explain why gay men experience adverse mental health outcomes at disproportional rates compared to heterosexual men. His theory was further expanded to include other minority groups, including racial minorities (Jackson et al., 1996), people with mental illness (Hoy-Ellis, 2021; Vargas et al., 2020), aged Black people (Carden et al., 2020; Forrester et al., 2019), Black sexual minorities (Ayayi & Syed, 2021), and gender-diverse Black folks (Cyrus, 2017). Minority stress, Meyer (1993) states, occurs due to the conflict between minority status and the norms of the dominant society. Belonging to a minority group puts one in a constant struggle with the predominant society, causing chronic stress, which leads to disproportionate rates of illness compared to members of the dominant cultural group (Meyer, 1993).

Sources of stress for members of minority groups can be divided into distal and proximal stressors. Distal stressors arise as conflict between the minority and overarching culture, such as overt racism and violence against the minority group, such as police violence against Black people and structural discrimination in employment and housing (Jackson et al., 1996; Ramirez & Galupo, 2019 Sehatzadeh). Distal stressors can also be experienced by come to minority people in more subtle day-to-day racism (Essed, 1991), such as an employer asking a Black woman to change her natural hair to be more "professional," which has the veiled meaning of asking her to conform to Eurocentric norms (Winters, 2020). Both overt and covert experiences of racism negatively impact the target of discrimination (O'Reilly, 2020; Williams et al., 2019).

Distal stressors, proximal stressors, or internalized self-stigma also contribute to the cumulative stress experienced by a minority group member (Willis et al., 2021). Self-stigma develops through socialization from the larger society that indoctrinates young members of minority groups into rejecting themselves for their held minority identity (Frost & Meyer, 2023). In Meyer's (1993) seminal work, he measured self-stigma stigma in gay men. He found that higher levels of stigma led to higher levels of experienced stress. An essential aspect of self-stigma in minority stress-theory is the concept of "concealment" (Frost & Meyer, 2023).

Internalized stigma leads the individual to hide or conceal factors about themselves that may lead to further stigmatization and isolation. At first brush, concealment is a protective mechanism; however, it may also lead to further internal stigmatization and rob the individual with mental illness of a chance to connect with community members who could validate or provide social support (Frost & Meyer, 2023). Nevertheless, mental illness continues to be highly stigmatized; therefore, "coming out" about one's mental illness or involuntary hospital stay could be a risky choice (Corrigan et al., 2010). The stigma surrounding mental illness continues to exist in African Canadian communities (Fante-Coleman et al., 2023; Waldron et al., 2022; Waldron, 2020), which increases the risk of "coming out" about one's mental illness. However, when African Americans share their experience of mental illness with others, it has beneficial effects, including decreased self-stigma and improved ability to ignore distal discrimination (Corrigan et al., 2010). In the current study, participants were asked about their experiences living with mental illness and experiencing involuntary psychiatric care influences and how these intersect with their experiences of stigma. Meyer (1993, 1995) also cites the term "minority coping" as a positive effect of minority stress. He found in his seminal research on gay men that connecting with other individuals experiencing homophobia buffered against the effects of minority stress, particularly internalized homophobia (Meyer, 1993). Black Canadians cope with the stress associated with distal and proximal racism through spirituality (Beagan et al., 2011), seeking out racial oases (Daniel, 2021), and support from family and friends (Houshmand et al., 2019; Thomas Bernard et al. 2020), and community activism (Lafreniere et al., 2023). In the current study, minority coping is explored by examining the role of family, community, and the health care system in participants' experiences with involuntary psychiatric care.

Meyer (1995) states that minority stress does not simply arise from experiencing discrete events of prejudice and discrimination, but rather, it is the "…totality of the minority person's experience in the dominant society. At the center of this experience is the incongruence between the minority person's culture, needs, experience, and societal structures" (p. 39). Mary-Frances Winters talks about the phenomenon of living as a Black person within a White-dominated society in her book Black Fatigue: How Racism Erodes the Mind, Body, and Spirit (2020). She defines the term Black fatigue as "repeated variations of stress that result in extreme exhaustion and cause mental, physical, and spiritual maladies that are passed down from generation to generation" (p. 33). This chronic and unrelenting exposure to the stress of discrimination leads to a term that Geronimus and colleagues (1992) called “weathering,” which refers to the chronic wearing down of one’s body systems, eventually leading to the disease process. Stress has a profound biological impact that increases morbidity and mortality in those who experience it (Forrester et al., 2019). Social stress, like racism, activates the same brain structures as physical pain (Hobson et al., 2022). When stress is perceived, the body secretes corticotropic-releasing hormones and adrenocorticotropic hormones, followed by the release of glucocorticoids, including cortisol, stimulating the sympathetic nervous system. This process is adaptive and protects human life in times of danger. However, activating the sympathetic nervous system also suppresses the immune system. Over time, in cases of chronic stress, the body does not return to its baseline or homeostasis. An imbalance of the body’s systems increases the allostatic load, leading to the disease processes (Forrster et al., 2019). An increased allostatic load through the impact of chronic stress is a factor in the health disparities in people of the African diaspora, including the increased rates of cardiovascular disease (Felix et al., 2022), dementia (Forrester et al., 2019), and breast cancer (Parente et al., 2013). Furthermore, higher prevalence of these conditions in people of the African diaspora continues even when factors like socioeconomic status, individual health characteristics, and health behaviours are controlled (Forde et al., 2019; Hicken et al., 2014; Lee & Hicken, 2016; Powell et al., 2016, Tavares et al., 2022).

The weathering hypothesis can also be applied to the development of mental illness (Misiak et al., 2014). There is a strong biological link between chronic stress and mental illness. Compared to healthy controls, allostatic load (AL) is elevated in first-episode psychosis, with higher allostatic loads evident in people with more severe depressive symptoms (Misiak et al., 2018). Increased AL has been measured in people with schizophrenia, with higher AL present with more severe positive symptoms of schizophrenia (Nugent et al., 2015). For bipolar disorder, higher AL was found in people with more severe manic symptoms (Berger et al., 2020). Therefore, in this study, participants' experiences with involuntary psychiatric care and the symptoms that may have led to their admission are examined holistically through the lens of weathering. Furthermore, the participants were asked to reflect on their experiences with held identities such as race, gender, and class and how the summation of living at the intersection of these identities contributed to their involvement with involuntary psychiatric care.

In the current study, Minority Stress Theory was used to conceptualize the experience of undergoing involuntary psychiatric care as a person of African descent. By applying minority stress theory, including the ideas of weathering and allostatic load, this researcher hopes to understand how chronic stress has played a role in how participants interact with the mental health care system, both through understanding minority stress and the role of minority coping. However, examining each held identity alone did not allow for a complete understanding of the phenomena in this study. When people with multiple identities (i.e., minority race and minority sexual orientation) were studied through the lens of Minority Stress Theory, participants were found to have higher levels of stress but also higher levels of resilience (Meyer, 2010). Therefore, examining the intersection of held identities is imperative to understand how each participant is situated within their experience of involuntary psychiatric care.

Intersectional Framework

In the context of this study, an intersectional analysis will be interlaced within Minority Stress Theory to understand how the race of the participant interacts with other held identities, such as gender, disability, and class, to create their unique experience with involuntary psychiatric care. In seminal work by Hill Collins (1989), she identifies that African American women have a unique viewpoint of reality due to their interlocking identities as Black and woman. This experience holds for other identities outside the margins of dominant White-male-heteronormative-able-bodied-neurotypical-Christian positionality. Pursuing an exploration of multiple overlapping identities is considered an intersectional analysis. This framework was developed by Black legal scholar Kimberlé Crenshaw (1989, 1991) to explore legal cases of Black women who found themselves wedged between civil rights and gender-based case law when fighting against issues such as workplace harassment. Crenshaw's original positions illuminated the struggle of Black women – whose legal counsel was forced to choose case law highlighting civil rights or case law that highlighted discrimination based on gender – and found that to understand the nuances, one must examine the intersection of identities to comprehend the unique experiences of Black women pursuing legal justice (1989; 1991). Crenshaw's work remains relevant to discussions of Intersectionality, and this framework has been expanded to include any identity that leads to marginalization, such as those with mental illness, those living in poverty, immigrants, people with disabilities, gender non-conforming individuals, and people of the 2SLGBTQ+ community. An example of how multiple intersecting identities contribute to further marginalization was shown in a study by Foster et al. (2022) with older Black women. Black women over 55 in Toronto experienced poor mental health, especially anxiety and depression, due to the cumulation of gendered racism and immigration-related discrimination.

The intersection of age for Black Canadian women also played a role in mental health, as Foster et al. (2022) found that participants retired later than their male counterparts and later than White women. Poverty and health-related issues greatly impacted participants' mental health (Foster et al., 2023). Goddard-Durant et al. (2023) interviewed young Black mothers in Toronto. Intersecting identities can also include class and gender, as demonstrated by Goddard-Durant et al. (2023). The researchers found that these women had many racist, sexist, and xenophobic experiences during their youth, perpetuated by the school and child welfare systems. These experiences of anti-Black racism, poverty, and involvement with child welfare led to mental health challenges for participants (Goddard-Durant et al., 2023).

For Black Canadian youth who identify as 2SLGBTQ+, another layer of complexity is added when this group seeks mental health support. Lowe (2023) found that for Black transgender and gender-diverse Nova Scotians, negative experiences with the medical system are common, including discrimination based on race and gender identity. Fante-Coleman et al. (2023) found that Black youth in Ontario are reluctant to report mental health concerns or their sexual orientation to health professionals or families for fear of compounding stigma from these groups. Further, the participants in this group shared that mental health concerns can go undiagnosed or are over-diagnosed based on health providers learning about their sexual orientation, for example, telling youth that their mental health concerns will go away when they "figure out" their identity, and misdiagnosing diverse gender identity and sexual orientations as mental health concerns (Fante-Coleman et al., 2023).

Crenshaw (1989) states that looking at a person with multiple marginalized identities from only one axis works to "erase" this person. She gives the example of workplace discrimination against Black women that puzzled the courts. Judges struggled to determine what legal precedence to use – should these cases be judged against other racial discrimination cases, or should they be held against cases of workplace sexism? This challenge of fitting a plaintiff into a categorial box of race or gender works to marginalize the Black woman further, as she must choose between civil rights or feminism. Black people with mental illness also face a similar struggle—to fight for civil rights or to push against the stigma and discrimination faced by those who have a mental illness. In the current study, an intersectional framework will allow those with multiple and intersecting identities to be seen as complex beings rather than trying to fit them into a box of "race," "mental illness," or "gender." Crenshaw (1989) gives the following illuminating analogy to express how analyses that do not consider intersecting identities work to marginalize further those who are already discriminated against:

> Imagine a basement which contains all people who are disadvantaged on the basis of race, sex, class, sexual preference, age and/or physical ability. These people are stacked – feet standing on shoulders – with those on the

> bottom being disadvantaged by the full array of factors, up to the very top, where the heads of all those disadvantaged by a singular factor brush up against the ceiling. Their ceiling is actually the floor above which only those who are not disadvantaged in any way reside. In efforts to correct some aspects of domination, those above the ceiling admit from the basement only those who can say that "but for" the ceiling, they too would be in the upper room. A hatch is developed through which those placed immediately below can crawl. Yet this hatch is generally available only to those who—due to the singularity of their burden and their otherwise privileged position relative to those below—are in the position to crawl through. Those who are multiply-burdened are generally left below unless they can somehow pull themselves into the groups that are permitted to squeeze through the hatch. (p. 152)

This analogy demonstrates the urgency of applying an intersectional framework in research such as the current study, which will share the stories of people who have at least two intersecting identities: Blackness and mental illness. In the current study, the "hatch" attempts to become a wide-open door, allowing all people and their intersecting identities to share the totality of their experience with this researcher.

Al-Faham et al. (2019) expands on Crenshaw's ideas, stating that movements focused on only one marginalized identity (e.g., just women or just race) further marginalize people who hold multiple marginalized identities (i.e., Black women) and diminish the nuances that land at the intersections of multiple identities. They propose that intersectionality can be used as an academic tool for critical analysis. One way this can be done is by pinpointing "processes of differentiation (e.g., racialization) and systems of domination (e.g., colonialism) that set marginalized groups apart from dominant groups" (Al-Faham et al., 2019, p. 53). In the current study, differentiation processes may include migration status, gender identity, sexual orientation, disability, age, and socioeconomic status. All participants will be Black; therefore, racialization will be contextualized along the axis of other held identities. Systems of domination that will be explored will include involuntary psychiatric care and the health care system. Other systems of domination that participants bring forward may include employment, housing, social services and child protective services, police involvement, and the power differentials between patients and health care providers.

The dilemma of simplifying identity to a single category is minimized in the current study using an intersectional approach. Unfortunately, much of the past literature regarding involuntary psychiatric care has not taken an intersectional approach. Even when a study collects participants' demographic information, no analysis of the role of race or gender is conducted. Only looking at one identity, states Crenshaw (1989), serves to make those who are "multiply-burdened" further "invisibilized.". Therefore, to ground this research in the complex experiences of participants, this study will look at the intersections not only between race and experience of involuntary psychiatric care but also between race and other held identities, such as migration status, gender identity, sexual orientation, age, disability, and socioeconomic status.

Looking at identity and discrimination through an intersectional lens allows for a further process toward ending agents of oppression such as patriarchy and racism (Al-Faham et al., 2019). It is not enough to reorganize other theories to include excluded folks; for example, rearrange feminism to include Black women. The framework must be reimagined to include overlapping identities. This is where an intersectional framework comes in. Crenshaw (1989) states that for Black women, “the intersectional experience is greater than the sum of racism and sexism, [and] any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated” (p. 140). For the participants of the current study, it is not sufficient to try and understand their experience of race alone or their experience of involuntary psychiatric care and mental illness alone. To understand their experience, one must look at the intersection between race and involuntary psychiatric care. Other intersecting identities will add richness to understanding the experience of participants. Jordan-Zachery (2006) states that intersectionality should be used to examine and illuminate within-group differences. Without intersectionality, analysis on only one axis may lead to “collapsing groups into monolithic general categories” (p. 209).

Intersectionality can lead to movement and action. Using intersectionality to move towards action is essential for groups that have been marginalized. Hill Collins (1989) states that not only do oppressed groups see reality differently than the dominant group, but the oppressed group is also often unable to change their oppressed status due to unequal access to resources compared to the dominant group. For example, although Black people with mental illness may see problems within the mental health care system, they are often unable to enact change due to structural limitations resulting in further marginalization, such as poverty or disability. The experience of multiple marginalized identities can lead to resistance and movement toward change (Hill Collins, 1989). However, it can also contribute to further health disparities and distress in the same manner as increased allostatic load (Lick et al., 2013). In the current study, intersectionality will be used to understand the participants' experiences and move toward change within the healthcare system.

Along with using intersectionality to understand the nuances of the intersecting identities of participants, this study uses intersectionality to critically examine the structural forces that enact power upon participants, including psychiatry and nursing, police and law enforcement, and the legal systems. Hill Collins (1990) describes these forces as the matrix of domination, the interlocking identities or powers that create a "both/and" understanding of identity and oppression. The matrix of domination has four realms that enact oppression: structural, disciplinary, hegemonic, and interpersonal (Hill Collins, 2006). Within the matrix of domination, the structural refers to the organizational aspects, such as laws like the Involuntary Psychiatric Treatment Act. The disciplinary axis of the matrix refers to "the bureaucratic organizations whose task it is to control and organize human behavior through routinization, rationalization, and surveillance" (Hill Collins, 2006, p. 8). An example of the disciplinary axis in this study is the protocols within health authorities and policing. Policies that do not recognize intersectionality yet claim to govern all people equally are examples of the disciplinary realm of control. Hegemonic, states Hill Collins (2006)), is where oppression becomes "legitimate" through the people who enact oppression. In the current study, those who intact and uphold the laws are part of the hegemonic domain, including psychiatrists, nurses, social workers, law enforcement, and judges. Finally, the interpersonal aspect of the matrix of domination refers to how we uphold the oppression of another. This interaction plays out in *intra*personal interactions (interactions with self) and *inter*personal interactions, such as interactions between men and women and gender non-conforming people, White and Black, colonizer and colonized, and Nurse and patient. Through this domain, Hill Collins (2006) identifies that within the matrix of domination, no one is purely an oppressor or a victim; the intersectional forces crisscross and interact to create varying levels of power and oppression.

By understanding how intersecting identities interact with structural forces, the researcher hopes to move towards resisting the matrixes of domination. Hill Collins (1990) states:

> Empowerment involves rejecting the dimensions of personal, cultural, or institutional knowledge that perpetuate objectivation and dehumanization. African-American women and other individuals in subordinate groups become empowered when we understand and use those dimensions of our individual, group, and disciplinary ways of knowing that foster our humanity as fully human subjects. (p. 547)

The current study hears the stories of diverse Black Nova Scotians who have experienced involuntary psychiatric care. The theoretical basis of this study is intersectionality and minority stress theory. Participants identify as Black Nova Scotians and had experienced some form of mental illness that had led to being held involuntarily in a psychiatric facility. The experience of being Black in a society built on colonialist and White-supremacist ideals leads to chronic stress. This study aims to understand how participants experience stress based on their race and other held identities as fully human subjects.

Narrative Inquiry

Narrative inquiry was used as a methodology, research method, and data analysis tool in the current study. In the following paragraphs narrative inquiry will be defined and the appropriateness of this framework will be justified.

Narrative inquiry, explains Polkinghorne (1995), is the co-creation of a story based on past events or ideas about the future. Through conversation and interviewing, meaning about the story is created. Through this meaning-making process, which Polkinghorne (1995) refers to as explanatory narrative inquiry, phenomena are explained and understood. In the current study the primary researcher used explanatory narrative inquiry in her interviews with the participants.

Not only is narrative inquiry able to explain phenomena, there are also parallels between narrative inquiry and the African storytelling traditions that make this framework an appropriate choice for the study's sample. Fearon (2024) states that storytelling for African and diasporic African communities is a form of resistance and healing and can be used to share histories and imagine futures. For the current study, narrative inquiry is understood as a qualitative methodology but is also grounded in the principles of Africentrism. As stated previously, Este and Thomas Bernard (2019) identify four main principles of Africentrism including the interconnectedness of all things, collective identity, affective dimension, and spirituality. In the current study, all four principles were prioritized when co-constructing narratives with participants. For example, a participant investigating their first involuntary psychiatric admission could not fully understand the experience without exploring the relationships with their neighbourhood (the interconnectedness of all things), the relationships and shared history with their elders (collective identity), how the experience made them feel (affective dimension), and the impact of involuntary care on their relationship with a higher power or their purpose in life (spirituality) (Este & Thomas Bernard, 2019). These principles were identified as areas for inquiry as subthemes in the interview guide (e.g., questions focusing on the role of community and family in the experience of involuntary psychiatric care) and during data analysis by examining how these emerged in the collective narratives.

Chapter 4: Data Collection and Analysis

The following chapter details the current study's data collection and analysis methods. The discussion will begin by exploring sampling and recruitment methods. Data collection methods will be examined, exploring specific narrative inquiry methods used. The chapter will close by presenting methods used for data analysis.

Research Design

Study Sample

The current study recruited six participants who identify as Black (i.e., African/Caribbean/Black Nova Scotian, African/Caribbean/Black Canadian, Black, African, or Caribbean, or other Black ethnicities, i.e., Nigerian, Ethiopian, mixed/biracial/multiracial). Recruited participants had experienced involuntary psychiatric admission or had been under a community treatment order (CTO) in Nova Scotia. At the time of the study, all participants were over 18 years old and were able to read and understand English. At the time of the interview, participants were not presently under involuntary psychiatric care or on a Community Treatment Order.

Participants in the current study ranged from 24 to 65 years old. All participants identified as cisgender and heterosexual. There were four male participants and two female participants. All participants were born in Nova Scotia and live within Halifax Regional Municipality (HRM). All participants are living in the community. Of the male participants (n = 4), three live with their parents, and one lives independently in a rented apartment. The two female participants live in rented accommodations, one with her husband and the other alone.

All participants experienced involuntary psychiatric care at one of the three acute psychiatric units in Halifax Regional Municipality (HRM): 6 Lane or 7 Lane, located in the Abbie J. Lane Memorial Building in Halifax, Nova Scotia, or the Mount Hope Acute Psychiatric Care Unit (formally Mayflower Acute Care) at the Nova Scotia Hospital in Dartmouth, Nova Scotia. Dates of admissions ranged from the early 1980s to 2023. Participants shared experiences from their involuntary admission. The mean number of involuntary admissions was 5.16, with the range of number of admissions spanning from one admission to eleven involuntary admissions. Only one participant had been on a Community Treatment Order. Diagnoses of participants that led to involuntary psychiatric care included schizophrenia, bipolar disorder, and unspecified psychotic disorder. Other diagnoses reported by participants included anxiety, intermitted explosive disorder, and Tourette's Syndrome. Most participants are supported by Income Assistance and the Disability Support Program (n = 5), while one is employed full-time.

Because diagnoses and insight into one's illness are fluid (Phahladira et al., 2019), identifying as having a mental illness was not an inclusion criterion for this study. Many people who have experienced mental illness do not have insight into or ascribe labels of psychiatric diagnoses to their symptoms (Belvederi Murri & Amore, 2019). Furthermore, involuntary admissions often occur with transient psychiatric symptoms that do not translate to a lasting disorder or diagnosis (e.g., drug-induced psychosis). Therefore, the primary researcher chose not to include diagnosis as a recruitment criterion so as not to exclude those who disagree with their diagnosis or experienced a transient diagnosis.

Participants could not be currently undergoing involuntary psychiatric care at the time of their participation in the study. This exclusion criterion was determined based on the increased vulnerability of a person undergoing psychiatric care. The study population (Black folks who have experienced compulsory psychiatric care) is already vulnerable to systemic marginalization. People undergoing involuntary psychiatric treatment have been deemed by a psychiatrist to not presently have insight into their illness to make treatment decisions for themselves. Therefore, this researcher decided not to recruit from the currently admitted population due to the additional vulnerability.

Along with race and admission experience, this researcher actively aimed to recruit diverse participants in terms of age, gender identity, sexual orientation, migration status, socioeconomic status, and ability. Participants with diverse backgrounds will enhance the data and the subsequent narratives collected.

Recruitment

Snowball sampling was used to find participants willing to help the researcher understand the experience of being a Black person living in Nova Scotia who have experienced compulsory psychiatric care. Snowball sampling is a method of recruiting participants by connecting with people who are not the target research population, but those reached through recruitment methods will connect the researcher with eligible participants. Snowball sampling is a known way of linking with hard-to-reach populations (Perez et al., 2013; Sadler Robins et al., 2010). In the current study, snowball sampling allowed the primary researcher to connect with the target population through social media and trusted community members. Recruitment took place between June to

September 2023. The researcher focused her recruitment methods primarily on relationship building in Nova Scotia's Black communities and through social media recruitment, and through recruiting at various outpatient mental health clinics within Nova Scotia Health.

The first stage of the recruitment process was sharing a recruitment poster (Appendix A) in key locations where potential participants may be present. Flyers are a low-cost way to introduce potential participants to the research study (Joseph et al., 2016). In addition, posters were placed on bulletin boards at community libraries, grocery stores, coffee shops, and university campuses around the province. Postering was widespread, but especially in Black communities and locations where a large proportion of Black Nova Scotians live (e.g., North end Halifax and Dartmouth, and Preston area).

Flyers were also displayed at mental health inpatient and community clinics. Specifically, flyers were displayed in inpatient units in Halifax, including Abbie J. Lane Hospital in Halifax, and Mount Hope Unit in Dartmouth. Posters were shared with outpatient community clinics that offer outpatient mental health services for folks coming from these units, and specialty clinics such as the Early Psychosis Program and Mood Disorders Program in Halifax, Nova Scotia. Outpatient clinics are in the same areas as the inpatient clinics but targeted folks who perhaps had not been to the hospital recently but had had experience with involuntary psychiatric care in the past. Flyers were also posted at the Nova Scotia Brotherhood and Sisterhood Initiatives. The Brotherhood and Sisterhood clinics are not specifically for mental health care. However, potential participants, or clients who knew a potential participant, may frequent these clinics.

Even though participants must have been discharged from involuntary psychiatric care to take part in this study, by posting flyers at, and around, inpatient psychiatric units, people who had experienced involuntary care in the past or were in the process of being discharged from involuntary care could have contacted the primary researcher and be given information about the study. If the prospective participant was still admitted involuntarily, the primary researcher would have invited them to contact her when their care became voluntary.

Recruitment flyers were an effective way to share information about the present study at many locations where potential participants may frequent. However, it was not the primary method of recruitment. James et al. (2017) spoke with African American participants, ages 18-78, about recruitment strategies that best suit their needs. They found that word-of-mouth was the most favourable method for males and females of all ages. In addition, snowball sampling through social media was a helpful way to reach eligible participants, especially during the COVID-19 pandemic, as folks may not have attended in-person events as often as before the pandemic (Leighton et al., 2021). The primary researcher asked each participant after their interview if they knew anyone who may be interested in the current study, and if they would be willing to pass along the recruitment poster. Unfortunately, no participants were able to recruit other participants in this way. Participants either politely refused or stated that they did not know anyone who would meet the eligibility criteria.

Social Media Recruitment. Social media as a recruitment strategy has recently increased in popularity (Gelinas et al., 2017). Using social media in research "…may enable investigators both to reach wider segments of the population than may otherwise be accessible and to target individuals on the basis of personal information that, in many cases, allows researchers to infer their eligibility for particular studies" (Gelinas et al., 2017, p. 3). Social media recruitment may also be advantageous when looking for participants who experience stigma due to their psychiatric diagnosis (Sanchez et al., 2020) or their gender identity, such as transgender or gender non-conforming individuals (Guillory et al., 2018; Irbarren et al., 2017). Therefore, the primary researcher developed social media accounts on Facebook, Instagram, and Twitter from which she shared recruitment materials. Community organizations could also repost these materials to their social media pages, essentially mirroring the paper postering strategy online.

Although social media has been found to increase access to health studies and their potential benefits (Schmotzer, 2012), it cannot be used as a standalone recruitment method for Black participants. James et al. (2017) found that social media was most popular with young men and women aged 18-29 and relatively accepted by adults aged 30-50, but interest waned in older participants (ages 51 and up). Therefore, developing relationships with community leaders was essential in recruiting participants aged 51 and older, or those who do not use social media. In the current study, recruitment replied on postering, social media, and building relationships with community members to connect with eligible participants.

Community Recruitment. Community recruitment refers to using relationships and word-of-mouth to inform potential participants about the current study. This recruitment method took place through building relationships with leaders at Black churches and connections with key community members.

In his research with African Americans about recruitment methods, James et al. (2016) found that Black folks in America deemed recruitment through their pastor a trustworthy method for all genders and age groups surveyed. Participants stated that if their pastor expressed trust in the researcher, they would be willing to join the study (James et al., 2017). Therefore, the primary researcher of this study contacted leaders at various, Black-centered groups throughout HRM through their official social media pages and email, asking if they would like more information about the current study. The goal of these meetings was to build trust with church leaders. If they were willing, the primary researcher asked the church leader to share the recruitment poster on their social media page or church bulletin. The primary researcher also asked if other community leaders would be open to hearing about the current study. These meetings aimed to build good faith with congregation and community leaders and learn if they thought the current study was a good fit for their members. The primary researcher reached out to several churches in Black communities using the website African Nova Scotian Directory. Unfortunately, only two responses were received. The primary researcher shared information about the study, but neither resulted in a follow up conversation.

The primary researcher also applied the above technique to Black Community Groups. She contacted organizations through their social media pages and emails, requesting to speak with a group member willing to hear about the current study. Again, the goal of these meetings was to make the organization feel comfortable with the motivation of the study, and that the recruitment poster might be shared on the group's social media accounts. In addition, if they were unable, or unwilling, to share the recruitment materials, the primary researcher hoped that meeting with members of these groups might lead to other community connections. This strategy was more successful, and the primary researcher connected with several community organizations through social media who shared the recruitment poster to their social media pages.

In the current study, four participants were recruited by a registered nurse at an outpatient mental health clinic at Nova Scotia Health. This nurse provided potential participants with the recruitment flyers for their consideration. One participant was recruited through the Black Brotherhood Initiative. The source of the last participant's referral was unknown.

The recruitment aim was to attract 20 to 25 participants to this study; however, the final number of participants was six. This author believes that mistrust of agents of the health care system, especially White researchers like the primary researcher, might have contributed to low enrollment. Due to unethical research in the past, many Black North Americans are reluctant to engage in research studies (Washington, 2006). Mistrust, along with concerns about representing a whole group, confidentiality and repercussions related to disclosure may also be factors when African Americans decide if they would like to participate in psychiatric research (Williams et al., 2014).

Initial Participant Contact

Potential participants contacted the primary researcher via the phone number or email address provided on the recruitment posters. If the participant contacted her through telephone, the primary researcher followed telephone script (**Appendix B**) to explain the study to the potential participant. If the caller was eligible for the study, then we decided if they wanted to participate on Microsoft Teams or in-person. If they wanted to meet on Microsoft Teams, will made an appointment to meet and conduct the consent and interview. If they wanted to meet in person, the primary researcher sent them the list of meeting locations (**Appendix C**) via email or discuss on the phone where they would like to meet[5]. Once the list has been sent or the participant picks a location, I gave them a time that I will call again to confirm the appointment time. This follow-up phone call is needed because the primary researcher will have to book the room at the community location. I asked for their preferred method of communication (email, phone, or text message), confirmed their contact information, and confirmed when I will follow up with the possible dates and times of the interview. We confirmed the dates and times of the interview at the follow up contact.

If the potential participant contacted via email, the primary researcher replied to the email with the script in **Appendix *D***. In this email I asked for their preferred method of communication (email, phone, or text message) to give more information about the study, and to determine eligibility for the study, and, if they are eligible, we discussed their preferred location to meet (Microsoft Teams or in-person). Following the same

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[5] For instance, the primary researcher tells participant that there are various places around the province where we could meet and would give examples. The participant may say that they want to meet at Halifax Central Library, therefore, the list of meeting locations would not need to be sent.

format as if they had called, we arranged a time for me to call back to confirm the date and time of the interview.

Informed Consent

Although the consent process began during our first interaction by informing the potential participant about the study and what it entailed, the tangible consent form (**Appendix E**) was completed at the beginning of our interview meeting. Relevant to the current study was the issue that participants might have been experiencing cognitive deficits that could have interfered with their ability to understand written material and give informed consent. Cognitive deficits are one of the leading causes that interfere with decisional capacity (Dunn, 2006, Palmer, 2006). People with mental illness may experience cognitive deficits secondary to their illness (Knight et al., 2020; Mihaljević-Peleš et al., 2019). People with mental illness, especially those with bipolar and schizophrenia spectrum illnesses, experience symptoms that, when present, may interfere with the capacity to make autonomous decisions (Pons et al., 2020). However, excluding a group of people from research due to a diagnostic category goes against the ethical principle of justice (Canadian Institutes of Health Research et al., 2014). Therefore, the dilemma posed in this study was how to include people with mental illnesses in research while also ensuring that free and informed consent was given. This issue was addressed in the current study by providing an interactive consent process.

Palmer addresses the dilemma posed above in their 2006 article, in which they suggest strategies, such as an interactive consent process, to encourage informed consent in participants with possible cognitive symptoms. Palmer poses that the reader and researcher engage in recalling and re-explaining process of various aspects of the study until the researcher feels that consent has been reached. This method is a revision of the Macarthur Competence Assessment Tool for Clinical Research (MacCAT-CR), a comprehensive decisional capacity measure of acceptance to test a participant's competence in clinical research. Although inclusive, the MacCAT-CR takes over 20 minutes to complete and may not be necessary for all participants. Palmer (2006) recommends that shorter, more sensitive measures be used to determine baseline understanding and then use more extensive measures if needed. Further, Jeste et al. (2009) used a video presentation of their study to determine whether video instruction would result in the increased decisional capacity of people with schizophrenia enrolled in a clinical drug study. Decisional capacity was also measured with the MacCAT-CR and University of San Diego Brief Assessment for Capacity to Consent. Researchers found that those in the multimedia group had higher scores on decisional capacity than the control group (people with schizophrenia presented with a standard written consent form). Therefore, principles used by Palmer (2006) and Jeste et al. (2009) were both used to ensure decisional capacity for participants in the current study.

In the current study potential participants were given the standard consent form along with the same information offered in a PowerPoint presentation that breaks down each section of the consent form in bullet form and simple language (**Appendix F**). Each slide also had audio narration. By having audio and visual information, the primary researcher hoped to increase learning and memory (Jeste et al., 2009). In addition, critical aspects of the study were highlighted in an interactive quiz. This presentation allowed potential participants to demonstrate their understanding (or lack thereof) and initiated touchpoints throughout the consent process where the primary researcher was able to intervene and provide further clarification. The primary researcher also created a guide for herself of possible sufficient answers to the PowerPoint "quiz" to determine capacity to provide informed consent (**Appendix G**). This guide is based on *MacArthur Competence Assessment Tool for Clinical Research* (Appelbaum, 2007).

All interviews took place in person, so the PowerPoint was set up on a laptop in the meeting room. The participant had unlimited attempts to go through the "quiz." There was no score required to participate in the study. The purpose of the study was to increase understanding of what was required by the participant. If the participant could not engage in the conversation regarding consent due to cognitive deficits, or symptoms interfering with their learning, the primary researcher planned to initiate a conversation about their participation in the study. The primary researcher would have offered to reschedule the interview or encourage the participant to take a break and return. This method of consent procedure aimed to create an open dialogue about the study, where the participant felt like they understood the risks and benefits of engaging. All participants were able to answer the "quiz" successfully and able to give informed consent. After the participant consented, the primary researcher and participant completed the questions on the signature page (**Appendix H**) and recorded the participant's answer. The participant signed the consent form and signature page.

Participants were offered the possibility of receiving a copy of their interview transcripts within two weeks of the interview and were given two additional weeks to let the researcher know if they wanted to amend their data or remove their data from the study. They were informed during the consent process that data analysis would commence after this two-week period and told that data could not be removed once this process had begun.

Each participant received $50 cash for their time. If a participant started the interview but did not complete the study, they were still compensated $50. If the participant chose to conduct the interview virtually, there was little to no cost to them. Costs for virtual participation might have included data charges and childcare. If the participant chose to meet in another location, then costs would have included travel and childcare. The primary researcher discussed barriers to participation during the initial phone call and offered additional funding to cover these types of costs if it meant that the participant would be able to partake in the study. If the participant did not finish the study, they would still receive the agreed-upon amount from the primary researcher. No participants opted to use the additional discretionary funding. No participants dropped out of the study.

Data Collection

Data were collected through individual hour-long semi-structured interviews. All participants opted to meet in-person, although they were given the option to meet online via Microsoft Teams. Interviews were audio-recorded and transcribed verbatim by a transcriber hired by the primary researcher. Narrative inquiry was the methodology of this study, and therefore data were collected using narrative thinking and interviewing techniques.

Research Setting

Although the primary researcher was willing to travel throughout Nova Scotia, all interviews took place in HRM. HRM is made up of 16 distinct communities including Nova Scotia's capital city, Halifax. Historic Black communities such as Africville, East Preston, North Preston, Cherry Brook, and Beechville are also part of HRM. During the initial contact over email or phone, potential participants were provided a list of potential locations where a meeting could take place (**Appendix C**). Participants could offer suggestions if no location was convenient for them; however, all participants found a location on the list suitable for their needs.

Semi-Structured Interviews using Narrative Inquiry

Interviews are the mainstay method of data collection in narrative research. Using interview skills, the researcher elicits complex stories from participants and together they create narratives that explain a situation or an event. This study used an explanatory narrative research lens to inform data collection. Once consent is reached, the interview commenced. Kim (2016) describes two distinct phases of the narrative interview that yield rich data. The first phase is the narration phase and the second is the conversation phase. The present study used this method to elicit broad narratives along with more focused co-constructed stories.

In the narration phase the researcher allowed the participant to tell their story with minimal interruptions, or prompts, from the researcher (Kim, 2016) by simply asking, "tell me about your experience with involuntary psychiatric care." The researcher actively listened and observed non-verbal cues from the participant and the environment with the goal of allowing the participant to tell their story naturally, giving their control over what they wanted to share. Once broad stories were shared, the researcher guided the participant into the conversation phase. The primary researcher used a semi-structured interview guide (**Appendix** I) in the conversation phase of the interview to direct the topics that the primary researcher asked about, but it was a guide and was modified based on the participant's experience. The interview guide had three sections, each section relating to each of the three sub questions of this study:

- How does involuntary psychiatric care influence trust, help-seeking, and stigma within diverse Black Nova Scotians?
- What factors contributed to participants' placement under involuntary psychiatric care, and what role did family, community and the health system play in this experience?
- How did race, migration status, gender identity, sexual orientation, age, ability/disability, and socio-economic status play a role in the process leading to, during, and after involuntary psychiatric care?

With the above headings as a guide, three to four questions were developed for each topic area. Open ended questions were created to allow participants to freely share their experience of each topic area. Riessman (1993) suggests that using open-ended questions will allow a topic to be opened by the participant, allowing them to respond with meaningful answers. She also states that questions that elicit specific information should not be discounted, as they may also lead to a participant answering with rich, storied information (Riessman, 1993). The narration phase and the conversation phases occur in turn, but linearity of phases is not necessary (Kim, 2016). Riessman (1993) states that interviews with less structure will lead to greater control for the respondents. She goes on to provide the following guidance: “[p]rovided investigators can give up control over the research process and approach interviews as conversations, almost any question can generate a narrative” (Riessman, 1993, p. 56).

Questions regarding participants’ intersecting identities were explored in the third section; however, the researcher recognized that not all identities would necessarily be relevant to each participant. For example, a client might identity as heterosexual and may not feel that their sexual orientation had any bearing on their experience with involuntary admission. The interview then moved to the second phase of narrative research, the conversation phase.

The conversation phase allowed the researcher and participant to collaborate on a shared story. The researcher asked clarifying questions, leading the story towards the research objectives. This was not to say that the story was biased by the researcher, rather the researcher identified gaps from the narration phase and asked pointed questions to address these gaps (Kim, 2016). It is during this phase, states Kim (2016) that “…solidarity between the interviewer and the interviewee will be established, as both try to understand important aspects of the interviewee’s life…” (p. 169).

Data collection in narrative explanation, describes Polkinghorne (1988), is done through gathering facts, organizing facts into a cohesive story, and highlighting the significance of facts. Facts can come from a variety of sources, but in this study, facts were collected from personal memory. Although Polkinghorne (1988) states that facts often must be corroborated through comparing other sources of information and the stories of other participants, in this study the participant's memory was taken as fact, because the event that this research aimed to explain was the participant's unique understanding and perception of their reality. Positioning the participant's narrative as truth did not mean that the researcher would not mine for additional facts. Through data collection, the researcher placed events in chronological order to find gaps in the narrative (Polkinghorne, 1988). Gaps were addressed through additional data collection.

To uphold the explanatory aspect of this type of narrative research, the data should demonstrate causality, meaning that …they [narratives] should provide meaningful and complete answers to questions worth asking" (Polkinghorne, 1988, p. 172). This can be done through posing "what if" questions to understand an imagined course of events (Weber, 2012). For example, when wanting to understand if the presence of police in a participant's pathway to care lead to differences in admission rates, the researcher asked, "Do you think your experience in the Psychiatric Emergency Department would be different if a trusted friend or family member escorted you instead of police?" or "Do you think your admission to hospital would have been different if you were directly admitted from the outpatient clinic instead of being admitted through the Emergency Department?" Weber (2012) states that if the participant answers "yes" then causality is probably. An answer of "no" would inform the researcher that the concepts are not related (Weber, 2012).

After the interview was completed the audio file was shared via OneDrive to the transcriber for transcription. The transcriber signed a confidentiality agreement

(**Appendix J**). If the participant chose to receive a copy of their transcript, the transcription was sent to the participant within two weeks of the interview via OneDrive. The participant then had a chance to review the transcript and note their additions, changes, and items that they would like omitted. The primary researcher contacted the participant through their preferred means of communication (phone or email) one week after they have received the transcript and asked if there were any changes they would like made. If so, the primary researcher offered to meet via Teams or by telephone where the participant would tell the primary researcher of the changes. This process took 20-60 minutes of the participant's time. Only one participant opted to make changes to their transcript. The participant contacted the primary researcher by email and shared what statements they wanted to be removed. When contacted, all other participants stated that they did not want to make changes to their transcripts.

Data storage

All participant data was shared and stored electronically on Dalhousie's OneDrive server. Interviews were recorded using a digital voice recorder. Files were named using a number which corresponded to the participant's number. The file with the participant names and file numbers are kept on a password protected document on Dalhousie's OneDrive server. Once the interview was transcribed, the audio file was deleted. Completed interview transcripts were shared through OneDrive with the participant for their review. All participants had access to email and the internet; therefore, no hard copies of the transcripts were required. The signed consent form, interview transcripts, and document password list are stored on the primary researcher's private OneDrive account.

Interview audio was destroyed after it was transcribed. De-identified interview transcripts will be kept on the primary researcher's private OneDrive account and destroyed after five years, as per the recommendation of the Dalhousie Office of Research Services. Five years will be calculated from the time that the study was completed (approximately June 2023, to be destroyed June 2028). The interview transcripts may be kept indefinitely, but only if the participant agreed that it can be used for future studies on the Signature Page.

Results of this study will not reveal the identity of participants. Only de-identifiable data will be included in the final report and published in journal articles. Participants will not be identified by name, or any other identifiers. Each participant was assigned a number that connects the transcript with the participant. Study participants were informed via the consent form that quotes from the interview may be used in analysis and presentation of data, and that under no circumstances will any participant identifiers be used.

The process of anonymization was used to protect the identities of participants and occurred after transcription. The primary researcher used the protocol suggested by Thomson et al. (2005) for anonymization for secondary use of qualitative data. This protocol includes first replacing direct identifiers, then creating an inventory of common identifiers that should be removed or generalized (e.g., town names, hospital units). Additional proofreading will be completed before releasing the results to ensure there are no outstanding identifiers that should be anonymized. Finally, a database (kept on the primary researcher’s secure external hard drive) was created to allow the researcher to record her anonymization and reasoning for same (Thomson et al., 2005).

In addition to this protocol, the primary researcher will only share information such as community of participant, sexual orientation, or diagnosis as aggregated results to avoid re-identification. Pseudonyms will not be used, as they can be used in conjunction with other information to re-identify participants (Lubarsky, 2017).

Data Analysis

The data collected from this study was analyzed using a narrative methodology, guided by Polkinghorne’s (1995) work. The overarching aim of data analysis, as stated by Polkinghorne (1995) is “meaning making”, referring to understanding a human experience. In this case, the experience the primary researcher attempted to make meaning of is the experience of diverse Black Nova Scotians who have experienced involuntary psychiatric care. More specifically, a paradigmatic mode of analysis was used. This method, Polkinghorne explains, looks at the similarities and differences between themes, examines the parallels between participants’ stories, and ultimately, aims to create a common story among the participants of a group (Kim, 2015).

After the transcript was approved by the participant, the primary researcher then used the software NVivo 12 (version 12.7.1) to identify narrative themes, plots, and subplots, while referring to the audio recording for accuracy. Themes, plots, and subplots were chosen as they relate to the study’s research questions. Throughout data analysis, the primary researcher looked to answer the main question (what are the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care?) and sub-questions using a coding guide developed by the primary researcher (**Appendix K**) to make meaning about the diverse Black Nova Scotian experience of involuntary psychiatric care.

Data Saturation

Significance was placed on data saturation. Data saturation, states Kim (2016), is the process of coding interviews and looking for repeated themes. Kim (2016) states that six participants should be the minimum, provided that data saturation is reached at this point. By shifting one's focus away from the number of informants, the researcher can focus on the depth and the richness of the data, stopping only when the identified phenomenon has been fully explained (Kim, 2016). The researcher knew that she had reached this point when a new interview did not yield any new intelligence (Kim, 2016). The primary researcher interviewed six participants however data saturation was not reached in the time allotted for this study. Despite not reaching data saturation, the collected results are not invalidated. According to Kim (2016), this just meant that the phenomena had not been fully explained.

Chapter 4: Findings

This chapter reports the data from six semi-structured interviews from six Black Nova Scotians who have experienced involuntary psychiatric care. The narratives created through the following interviews aim to meet the following project objectives. The objectives of this project are threefold:

1. To explore the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care.
2. To understand the perspectives of Black Nova Scotians about placement under acute involuntary psychiatric admissions and community treatment orders.
3. To explore how experiences of being provided involuntarily psychiatric treatment influences diverse Black Nova Scotian people's interactions with the health care system before, during, and after involuntary psychiatric care.

Furthermore, the data collected from participant interviews attempted to answer the question: what are the experiences of diverse Black Nova Scotians who have experienced involuntary psychiatric care? Sub-questions include:

a. How does involuntary psychiatric care influence trust, help-seeking, and stigma in diverse Black Nova Scotians?

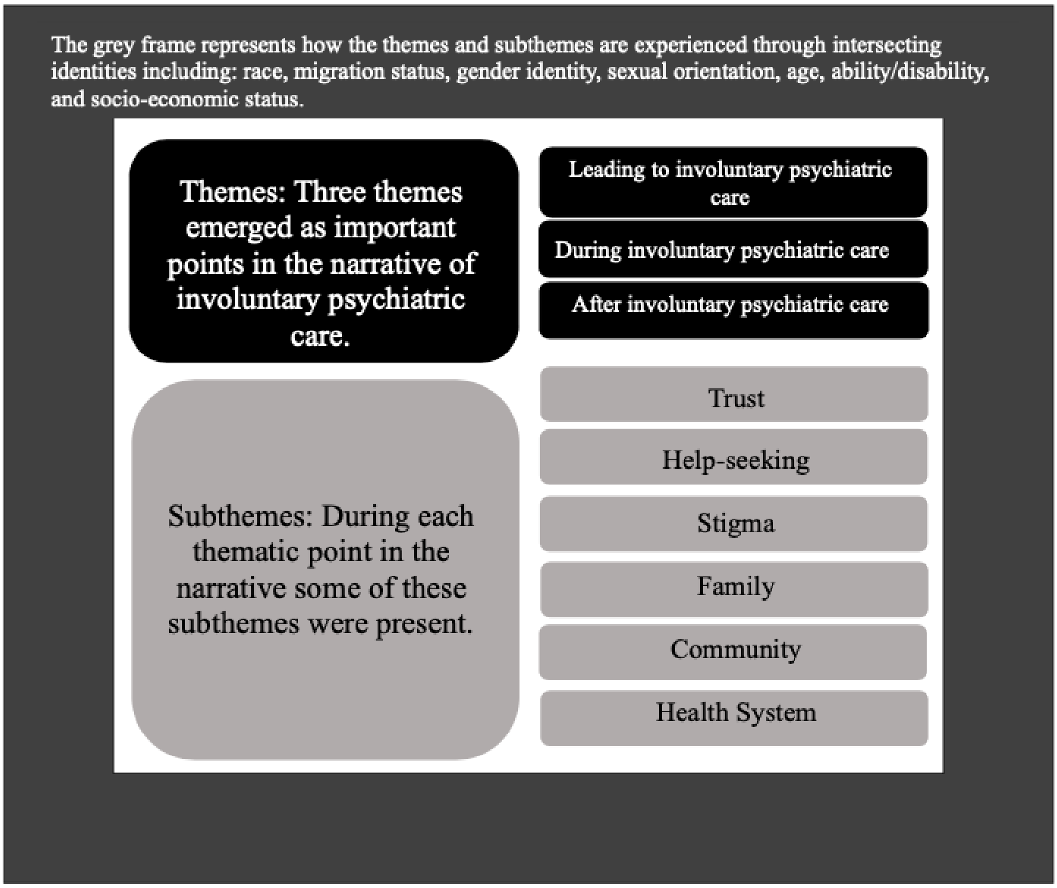
b. What factors contributed to participants' placement under involuntary psychiatric care, and what role did family, community and the health system play in this experience?

c. How do race, migration status, gender identity, sexual orientation, age, ability/disability, and socio-economic status play a role in the process leading to, during, and after involuntary psychiatric care?

When analyzing the findings of this research, a clear narrative emerged that separated the experiences into three distinct periods: leading to involuntary psychiatric care, during involuntary psychiatric care, and after involuntary psychiatric care. Quotes from participant interviews below are used to tell the story of the experiences of Black Nova Scotians as they moved through the involuntary psychiatric system.

Figure 2

Illustration of Themes and Subthemes



Leading to Involuntary Psychiatric Care

The first theme, *leading to involuntary psychiatric care,* is defined in this study as "factors leading to, feelings about, and comments about coming into involuntary psychiatric care." Quotes under this code are concerned with the events (internal and external) that participants experienced leading to the time that they were admitted involuntarily to a psychiatric unit. The primary researcher identified themes included in the study's research questions including trust, help-seeking, stigma, role of family, role of community, and the role of the health system. These sub-themes are defined in **Appendix K**. Along with these somewhat expected themes, the primary researcher also identified the intersecting identities of participants. During the time leading to hospitalization prominent intersections included race, gender, and socioeconomic status.

Trust and Help-Seeking

Trust, defined in this study as "To have faith or confidence in a person, quality, or thing; to rely on" (Oxford English Dictonary, n.d.), was an evident theme in the time leading to involuntary psychiatric care. Intertwined with trust was the concept of help-seeking. Help-seeking, states the American Psychological Association (2023) is "searching for or requesting help from others via formal or informal mechanisms, such as through mental health services."

The findings from this study show that for Black Nova Scotians, trust and help seeking are interconnected in the periods leading to, during, and after involuntary psychiatric care. Multiple participants reported that the wait to be assessed and admitted in the psychiatric emergency services (PES) was confusing, uncomfortable, and fear-inducing. They also stated that it was during this waiting time when they went from possibly wanting to be admitted voluntarily to being admitted involuntarily. Help-seeking and trust both appeared to diminish as symptoms of illness increased. Participants voiced that in the time leading to involuntary psychiatric care they wanted to trust members of the health system, like the Mental Health Mobile Crisis Team (MHMCT), but this trust often wavered as symptoms of illness intensified and insight into illness decreased. For example, Participant 5 stated that he went with the MHMCT to the Psychiatric Emergency Service (PES), but when he was waiting to be assessed by psychiatrists in PES, felt that he was being tricked or "trolled" by healthcare providers and wanted to leave, leading to an involuntary admission. He stated:

> It was kind of surreal. Like here I am in the hospital, and now I'm in like this locked room, like I'm in a holding cell. And there were people coming in asking me questions. And I think I wanted to say, 'Yes, I'll stay.' But my initial response was just like, 'No, get me out of here because you guys are trolling me.'…You see, it leads back to the symptoms of it, which are like, mistrusting…I don't trust what you're going to do or what you're going to say to me…So, I don't want to stay (Participant 5).

Participant 3, who was brought to the hospital by police, cited the relationship between law enforcement and Black people as a reason for not wanting to go to the Psychiatric Emergency Service to be assessed. He stated:

> Like how am I just going to sit around and just be like, 'Oh, yeah, these guys [law enforcement] are here to protect me' when on the TVs every day, like I'm seeing Black people are getting killed by police, especially in the Black Lives Matter movement. It was like it wasn't just George Floyd, it was like, you know, a bunch of Black people. All that time that's all you're hearing about. And like that really instilled in me like a fear of police (Participant 3).

There were other times that participants wanted to be admitted to the hospital but were turned away from inpatient psychiatric care. Fear with some level of insight appeared to drive participants to seek help from health care professionals. Participants reported calling emergency services or going to the emergency room to receive psychiatric care. Participants shared that despite wanting help and experiencing symptoms of psychotic illness, it was deemed by the assessing professionals that inpatient admission was not appropriate. Multiple participants stated that to be admitted they accessed emergency services (like MHMCT and presenting to the ER) several times before they were admitted. Sometimes these admissions would be voluntary. Other times, by the time the participant was admitted, the admission had to be involuntary due to the participant's lack of insight into their symptoms.

Participant 2 recollected on an experience where she disclosed psychotic experiences to a walk-in physician, only to be misunderstood. She described how this impacted future help-seeking behaviour.

> I was trying to explain…that I had a demon in me…to the doctor. He said, 'I can't help you.' And he told me that, 'We've all got our own demons.' That was it. And I never went back for months and months and months. The only reason why I went back was because my ears were infected. I'm glad that that lady doctor [that I saw the next time]…she really got on to [the first doctor] and said to give me some more [psychiatric] medication because she knew something was wrong (Participant 2).

Stigma

Stigma, as defined by Link and Phlem (2001), is the process of "labelling human differences and linking these labels to undesirable characteristics to create stereotypes, as well as using labels and stereotypes to separate "us" from "them", which result in status loss in social hierarchies and individual and/or structural discrimination." When coding the transcripts for stigma, the primary researcher was looking for mentions of feeling shame or embarrassment about psychiatric symptoms, or feeling unwilling to ask for help due to perceived ideas about what it means about a person who asks for mental health assistance. However, when reflecting on the events and factors that led to involuntary psychiatric care, participants did not mention stigma as a factor that changed trust or help-seeking.

Family

Family is defined by the participant and may include parents and/or step-parents, (step or half) siblings, partners, and/or (step) children. Families, in this case may include (step) grandparents, (step) aunts/uncles, (step) nieces/nephews. Families may also include "chosen family" who are not genetically related to the participant but act as of one of the roles above.

In the current study participants shared that their family members were essential for noticing the sometimes-subtle changes in the participants' behaviour and personality that preceded involuntary psychiatric care. Family members, including parents, siblings, and spouses, contacted mental health supports and helped the participant navigate the mental health care system. These actions by family members were vital as participants were, due to their level of psychiatric impairment, either unable or unwilling to access mental health support. When the family member portrayed trust of the health care system, participants were more willing to agree to seek help for their mental health concern. Some family members understood symptoms of illness due to past experiences with self or other family members who also have mental illness.

All participants reported female family members played an integral role in connecting them with the mental health care system. Several participants had positive experiences with their female family members noticing symptoms and helping the participant connect with mental health care supports. As the participants had diminished insight due to illness, it appeared that the trusted female family members provided information and guidance on navigating the health care system. Sisters of the participants were cited as important supports for many of the participants. One participant cited his ex-wife as the support person who notified his parents about changes in his behaviour.

But the involvement of female family members was not always positive. Several participants voiced conflict with female family members leading to admission to involuntary psychiatric care. Mothers often took the brunt of these negative recollections. One participant stated that his mother felt threatened by his behaviour and called the police to intervene, which led to an involuntary psychiatric admission. Another shared that his mother was his surety and told the participant that he needed to seek mental health support, or she would revoke her surety role, which would result in his incarceration.

Community

Community, in this study, is again defined by the participant, and may include friends, neighbours, community leaders, religious leaders, teachers, coaches, or informal supports (e.g., peer support persons, sponsors). When coding this theme, the primary researcher was looking to understand how community members interacted with participants during the pathway to involuntary psychiatric care. Leading to involuntary psychiatric care, community consisted of family members. Participants agreed to go to the hospital at the urging of their family members. No participants cited that non-related community members, including religious leaders, coaches, or friends, were part of their pathway to care.

The Education System. The education system, defined as the school system, school, and its faculty, was a sub-theme that emerged in the pathway to involuntary psychiatric care. Half of the participants expressed how being the only Black child in a White class was extremely stressful for them and related to their future experience of involuntary psychiatric care. Participants 2 and 3 went on to discuss how being the only Black child in their class was related to the development and the symptoms of their psychosis. Participant 2 recalled what it was like being a Black child learning about slavery in the 1980s. She stated:

> I was just the only Black person [in my class]. And it made me feel so embarrassed because they would talk about being Black. And I was just kind of just… I was young. I was in grade 11…And [learning about Black history] is what drove me… That's what… I could have made it to grade 12, but I didn't, you know [because I got sick]. You know, that's what happened…I was the only Black person [in my class], and I just felt so… I don't know, so embarrassed and uncomfortable, you know (Participant 2).

Participant 3, who attended grade school in the mid-2000s, stated:

> Both my parents grew up, you know, in Black communities. But I grew up in a White community in [HRM]. And when I, you know, kind of developed my psychosis, like part of it was honestly really going back to like the trauma and reliving the trauma that I had growing up in a White community. Because, like you know, for forever, I was like the only Black student in my class. And it almost… Like I said, one time that like it felt like I had egg on my face. You know what I mean? It was like it felt like there was something on my face

(Participant 3).

Building Community. A participant spoke about how he attempted to build community around his experiences of racism in 2020 and 2021. He compared how others perceived his actions in 2020, during the height of the Black Lives Matter movement, as a normal response to the anti-Black racism and police killings to how others understood his actions a year later. After protests for Black Lives Matter became less common, Participant 3 stated his actions were perceived as grandiose and symptoms of psychosis, leading his involuntary admission. He stated:

> I started just posting [on social media] different stuff about [my experience with White people in power as a Black man], and about how [Black people] need to stick together, and about how like I want to do like a rally, and like different stuff like that. And what it was, is it was like because I was so involved in [activism], I was still that much involved like a year later. And because there wasn't like a whole bunch of people downtown on their knees and stuff like that, and raising fists up a year later, then it looked like I was just really out of it (Participant 3).

The Health System

In the current study, the health system refers to formal services administered by a health care provider including, but not limited to, doctors (e.g., family physicians, psychiatrists), nurses, and social workers). It also includes the physical structures of the system (e.g., hospital units, emergency rooms, community clinics), and the broader "system" (e.g., laws and policies enacted by providers in the health system). Health system, in this context, also includes agents of the system that enact the policies and laws of the system (e.g., police officers, Child Protective Services, lawyers and judges).

Interactions with Police. All participants had interactions with law enforcement leading to admission into involuntary psychiatric care. Some participants reported neutral experiences with law enforcement and Mental Health Mobile Crisis Team (a response team which includes an officer) and shared the attitude of "if I respect them, they will respect me." However, some participants expressed that interactions with law enforcement in their pathway to care as stressful and fear-inducing. Participant 1 who has had previous negative interactions with police due to her involvement with sex work, reflected on being brought to the hospital by the police. She stated:

> The police, they would take me to the hospital…If I didn't get my [antipsychotic depot], they'd come to my address and take me to the hospital…I felt like I was under arrest…Oh, that there was strange. Oh, because I thought [the officers] were talking about me, and then I thought they were going driving someplace to kill me and…it was terrifying because some of the police are nice and some of the

> police are right evil (Participant 1).

Participant 3 voiced similar emotions of fear when police were transporting him to the hospital. He stated:

> [My first involuntary admission] was shortly after the whole Black Lives Matter movement. And so, I felt really scared around police…I had to get arrested in order to get in [the hospital]. So…[my hospitalization] started out, you know, pretty terrifying (Participant 3).

One participant shared that he had negative interactions with police when he was younger. Having the police involved in his pathway to care induced fear and caused him to flee when police arrived at him home for a wellness check. The participant fled through window where police jumped on him and transported him to the hospital.

Race and the Health System. Participants shared the importance of having Black health care workers assessing Black patients, and the possible misunderstanding or misdiagnosis that can occur, especially when assessing paranoia of law enforcement. Participant 3 voiced that the psychiatrists that were assessing him were mostly White, and of a different socioeconomic class than him, and therefore could not understand his experience. Not only could this get in the way of culturally safe care the participant felt that his symptoms were misunderstood; that what a White, upper class psychiatrist might call grandiose, the Participant called trying to get ahead and make something of his life. On this experience, Participant 3 stated:

> I'm saying [my views on police] in rooms [in Psychiatric Emergency Services (PES)] with White faces that are just looking at me crazy. Because in their mind, like police keep them safe, you know. And so that's how they look at it. And so, like I just feel like my case specifically is like a good example to show that like if

> there was a Black person [in PES], you know, who probably regularly gets pulled over by police, and doesn't have such a positive view of police in their life. When I'm telling them that I have some issues with police and paranoia towards police because of race-related issues, then they're not going to write that down as psychosis. You know what I mean? They're going to write that down as what it is…and not write that down as something completely different (Participant 3).

Direct Admissions. Direct admissions are admissions to a psychiatric inpatient, that can be voluntary or involuntary, and the admitting physician is usually the outpatient psychiatric or family physician. Only one participant spoke about admission to hospital direct from an outpatient clinic. Participant 4 stated that he presented to his follow up appointment at the outpatient team, but when he realized the psychiatrist thought he needed to be admitted to the hospital he fled. He shared that this was the first time meeting the outpatient team after his initial involuntary psychiatric admission, and he did not trust the team. The therapeutic alliance was further eroded when the attending psychiatrist informed Participant 4 that she would be admitting him again.

Restraint Use. Restraints are means in which patients are physically or chemically (through sedating medications) controlled. Participants shared their experiences with physical and chemical restraints leading to involuntary psychiatric care. Participant 2 explained the following:

> There was eight orderlies. And strapped on a bed. And then I lifted all them up, threw them, and everything. That's how much strength I had (Participant 2).

Other participants shared that they were given injectable medication meant to sedate. Participant 6 explained how he was picked up by police and admitted to the acute psychiatric unit, where he was put in the unit Therapeutic Quite (TQ) room (seclusion):

> And I remember a couple of my first days being there, going to there to the hospital. They put me into the TQ room before I even got admitted to the hospital…From emergency to the TQ room. I have no clue why they [put me in TQ], but I think they were just getting to know me, and stuff like that, and they might not like… They might have been leery of me (Participant 6).

Socioeconomic Status

Socioeconomic status, as defined by the APA (2023) is "the position of an individual or group on the socioeconomic scale, which is determined by a combination of social and economic factors such as income, amount and kind of education, type and prestige of occupation, place of residence, and—in some societies or parts of society—ethnic origin or religious background." In the time leading to involuntary psychiatric admission participants spoke about how poverty was a stressor leading to descent into illness. Participant 3 spoke about the role of the COVID-19 pandemic amplified ongoing stressors of income insecurity:

> The pandemic was going on. So, [life stressors were] even harder because I was struggling because I really couldn't do online school…So, I felt like I wasn't going to get my education, and then I wasn't going to be able to get a good job, and then I would be stuck in poverty forever…And it's like I can't just survive off… like $450 a month [on Income Assistance]. I was like I can't just continue living like this for another God knows how many years that we're in this pandemic…It was a lot to handle (Participant 3).

Participant 1 talked about the challenges of trying to continue working while her mental health was decompensating. She stated:

> I'm a lady of the evening, and I was a hooker on the street…When the schizophrenia would hit me, I would stay off the street. And I would say to myself, [Participant], when are you going to go back to the street to make some money, because you're getting broke? And I had addiction at the time (Participant 1).

Participant 3 spoke about his discrepancy between trying to get himself out of poverty and how his actions were viewed as “being out of touch with reality” to the health care team assessing his mental status. He stated:

> I think that like when you come from like low income, like it's just really easy to lose your touch with reality because your reality is so much different than everybody else's…Because the people that are diagnosing you…are people who are doctors, who are getting paid $200,000 a year. You know what I mean?...I was telling [the psychiatrist that was assessing me in psychiatric emergency], ‘You guys have no idea like what I go through, or where I come from, or anything like that. So, like how can you properly assess me?’…But I feel like if it was like someone who came from where I came from, and was Black in Nova Scotia, and understood, you know, what it’s like to live in [Black community in N.S.], …I don’t think they would have put me [involuntary psychiatric care] in January (Participant 3).

During Involuntary Psychiatric Care

The second main theme that emerged in the data was the time during involuntary psychiatric care. This time was defined by the primary researcher as the situations encountered, feelings about, and comments about being held under involuntary psychiatric care.

Trust

Participants reflected on their trust for the healthcare team during involuntary psychiatric care. At the onset of involuntary admission, most participants reported that they felt fearful about the admission in general. Others reported cautious trust of the health care team. Trust blossomed in the relationship between team and patient when the participant felt that the team took an active role to get to know them as a person, not just a patient. Conversely, when doctors rushed out of meetings and did not appear to take participants' opinions into account, participants endorsed less trust in the inpatient team. Participants reported feeling closer with nurses, social workers, recreational therapists, and care team assistants than with their psychiatrists. It appeared that even if participants had negative views of their psychiatrist, they still expressed trusting these other team members. Participants shared that they had more access to these staff members during the day, and these staff members were more hands-on with their care. Participants reports that small gestures such as giving them a pair of headphones to use or taking them to the hospital gym allowed participants to feel dignity and experience trust with this team member. However, they saw nurses, social workers, and care team assistances as reporting back to the psychiatrist, with the psychiatrist having the final say in their treatment decisions.

A prominent sub-theme that emerged in the theme of trust, was the feeling as if the inpatient health care team did not trust the opinion of the patient. Participant 5 stated:

> I didn't feel like I was a part of the decisions at all. I didn't feel like I had any kind of say in the matter. So, I just kind of went with what was going on so I could get out of there as quickly as possible (Participant 5).

One of the main concerns from participants during their involuntary admission was the date of discharge from hospital. Many participants felt they were ready to be discharged but the team did not agree, and the participant was held for a time longer than they felt was needed. Many participants voiced confusion as to why they were being kept longer on the unit. One participant had her husband advocate for her, stating that his wife was back to herself, but the participant continued to be an involuntary patient for another week. However, Participant 1, who has had multiple involuntary admissions starting in the 1980s, has seen improvement over the years in the team involving patients in the decision-making process. She stated:

> [In the 1980s and 90s] there was no doctor sitting down saying, 'Well, do you think you're ready to go home?' They would tell you when to go home…[Now] they're asking more your opinion. And they're getting to know you as a patient (Participant 1).

Family members were important in helping the participant trust the inpatient team. One participant stated that his brother played an active role in helping him challenge his misgivings of the inpatient team by encouraging the participant to trust the team. Participant 6 stated:

> It made me help trust [the inpatient team] more…Because [my brother] was like… He told me… 'they're just trying to help you and don't think anything negative, just think that going to get help. If you need any help, you're going to get help,' and stuff like that, right? So, I was like, 'All right' (Participant 6).

Help-seeking and Stigma

Participants shared that once admitted involuntarily help-seeking behaviours decreased. The ability to autonomously dictate care decisions is eliminated for involuntary patients and a Substitute Decision Maker is appointed for the duration of the involuntary admission. All participants recalled the hierarchy of their care team as their psychiatrist dictating care, including when passes off the unit could be given, what medications were trialled, if seclusion was given, and when the participant would be discharged. One participant who has had multiple admissions since the 1980s voiced that collaboration between the patient and the healthcare team has vastly improved, however participants still voice that they feel at the mercy of the treating team during involuntary psychiatric admissions. There are some areas where involuntary clients can maintain autonomy, but these choices are limited to day-to-day decisions rather than treatment decisions.

Family

Participants shared that family members were a source of support and comfort while they were admitted to involuntary psychiatric care. Participants stated that visits from their loved ones provided relief from being alone in the hospital. Participant 6 stated:

> [Being on the unit] made me feel uncomfortable. Not really scared, but like I'd have these moments where I'd shake. My brother would just say, 'Stay comfortable, stay good…Just like relax, take it easy.' He'd come over. He'd visit me…bring his friends…and he'd make sure I was fine and stuff…made me feel more comfortable and calmer (Participant 6).

Family members served as advocates for participants during their involuntary psychiatric admissions and provided a place for participants to get a break from the hospital through overnight passes from the hospital.

Community

Lack of community arose in the narrative during participants' experiences of involuntary psychiatric care. Participant 2 reflected on the loneliness and lack of community she felt while in the hospital involuntarily. She stated:

> It was traumatizing…I'm telling you, it was traumatizing…You don't get no visitors, and you don't really know anybody, you know…it's just it's the same thing – lay down, go watch TV, lay down, eat, and wash, and whatever…It's really boring and lonely…I stayed in my bed. I was so miserable…And nobody really to talk to because they were all strangers. And they were nice to me but,

> you know, you can't really confide in them or nothing…Oh my gosh…[I felt] lonely and confused, and so sad. And they had me praying for me to get out of there. But sometimes my prayers come true, sometimes they don't come true. [laughs] (Participant 2).

The Health System

Participants were asked about their experience being Black while being involuntary admitted to a psychiatric unit. Most participants felt that race did not play a role in the care that they received during involuntary psychiatric care. When asked what it was like being a Black woman on the acute mental health unit, Participant 2 stated, "Oh, that don't bother me… They treated me nice there." Participant 5 stated, "…I feel like I was treated fairly. I feel like I was treated with respect." However, participants voiced that despite staff being kind, they felt "caged" and that involuntary admission put a restriction on their liberties.

Participant 3 expressed that being admitted involuntarily intersected with his experiences as a Black man in a predominately White community. He stated:

> I was [explaining my experiences of racism] to the people in the hospital who were assessing me, and they were like, 'Clearly this guy's lost it.' You know what I mean? …I feel like I was in the wrong spaces. I was talking about myself in the wrong spaces. And if I was in the right spaces, then a lot of things would have been avoided (Participant 3).

Physical and Chemical Restraints.

Participants shared their experiences with physical and chemical restraints while under involuntary psychiatric care. Participant 4 describe his time admitted involuntarily, "I just felt that I would take pills every day and sort of ride the wave with Lorazepam"

(Participant 4). One participant reflected that he was placed in TQ for smoking in his room. Despite being in the height of mania, Participant 5 had some awareness that not meeting behavioural expectations of the unit could lead to him being placed in TQ. When asked if he was placed in TQ during his admission, he stated:

> No, I kind of understood what was going on. You know what I mean? I was like, I don't want to go in [to TQ] so I'm not going to act up… I was like, Okay, well, that guy said he didn't want to stay, and kicking and screaming, and they just threw him in the padded room. So maybe I better…act calm…It was more like a fear thing, yeah (Participant 5).

Treatments. Treatments refers to medications or actions provided to participant as a remedy for symptoms. These may be provided by health system, the participant themselves, or others not related to health system (e.g., self, family, clergy, community). In the time during involuntary psychiatric care, participants reflected on the medications and treatments that were trialed. Participant 1 shared her experience with electroconvulsive therapy (ECT). She stated:

> I said, 'No, no, no, I don't want that machine on me.' And I've seen it in movies, right? … I took six shock treatments. My mother ordered it. That I take these shock treatments. and bring me back sensible again (Participant 1).

Participants shared that they often had to trial several medications over multiple years before they found a therapy that worked for them. Participant 1 went on to explain the mediation trials she has had as an involuntary patient.

> I was on a different medication. I was on prochlorperazine…I was on Stelazine, Cogentin…I went through hell with schizophrenia for 30-some years. And they just now found out how to maintain it, control it in 2004…they knew to give me the needle in my hip…then things started getting better, and I can control myself much better…Yeah, I was right on board [with the antipsychotic depot]. I said,

> ‘Whatever you can do to slow down the schizophrenia, these thoughts that’s going through my head, and the voices. I said, I’m willing to do whatever you want.’ They said, ‘You’re going to have to stay in the hospital for two more weeks so the medicine can work in your system.’ And I’ve been well on the needle ever since (Participant 1).

Participant 6 stated:

> They tried liquid Haldol…And then they tried…risperidone…and Seroquel…And none of those drugs worked. So eventually the doctor got handed over, and he worked out that the Invega [paliperidone] was the best drug for me…It was [frustrating] being put on all these different medications…The flupentixol, I didn’t mind. But I was just having problems on it…I had trouble walking…(Participant 6)

Several participants reflected about the mismatch of objectives between the healthcare team and participant. A participant explained that he did not agree with the diagnosis he was given in the hospital (psychosis) and felt that his experience would have been better captured by a different diagnosis. Another participant voiced his frustrations of not being able to take a pass from hospital grounds for the first three months of his admission.

Participants were asked to reflect on their admission now that they are voluntary patients and asked if they felt it was helpful. Participant 4 stated:

> I do think so. Because it let them like get a whole month to actually diagnose me. Which I didn’t mind that. Like I figure if you’re dealing with somebody’s mind, then you want to like take the time to get to know, okay, what is actually going on with this person? How can I help them the best? So, a month didn’t really seem out of place to me (Participant 4).

Socioeconomic Status

Income. When reflecting on his involuntary admission, Participant 4 felt he did not agree with the admitting diagnosis of psychosis. He agreed that he was at risk to experience mental deterioration but did not agree that it was based on illness, rather it stemmed from psychosocial factors. He stated:

> [I felt] that my rights were being violated a little bit…I was at risk of mental deterioration based on my living and housing situation. [But now I'm] labelled with psychosis, held for 30 days, and started on a long term medication (Participant 4).

Regarding his yearlong admission, Participant 6 stated:

> Well, I wasn't so lonely because a lot of my friends were there. But less boring, it would have been a lot better if I had like some internet or some TV… And if I had more money, more spending money when I went into the hospital, it'd be a lot easier to gain access to certain things…like clothing or food or drinks or something like that. (Participant 6)

Participant 6 stated that these small comforts like being able to buy a coffee, would have had a great impact on his mood and hope.

Housing. Participants 4 and 6 spoke about the connection between housing and involuntary admission. Participant 4 noted that housing was the barrier for discharge. He stated:

> At that point [close to discharge], it was nothing to do with psychosis…It was because of [housing]… They used the excuse I was likely to deteriorate…I was still involuntary. (Participant 4)

Participant 6 lost his placement in his apartment due to his lengthy admission. He stated:

> I felt like [the hospitalization] wasn't necessary at all. But then I stayed there in the hospital for about six months. Yeah. I ended up losing my apartment over [being admitted]. And that was really… That sucked (Participant 6).

Participant 6 reflected that he was discharged to a shelter after this admission because he had lost his apartment during his admission.

After Involuntary Psychiatric Care

The code *after involuntary psychiatric* care refers to the situations encountered, feelings about, and comments about the experience after experiencing involuntary psychiatric care. This part of care includes experiences with the outpatient psychiatric team and reintegrating into life after an involuntary admission.

Trust

Several participants reflected their understanding of their diagnosis and treatment after discharge from involuntary psychiatric care. Multiple participants voiced their satisfaction with receiving a long-acting antipsychotic depot to manage their psychotic illness. Participants voiced trusting their outpatient teams, stating that when their outpatient psychiatrist changes the dose or route of their medication based on patient-preference it makes them feel valued and increases trust in their healthcare team.

However, not all participants trust their outpatient team. A participant who experienced a direct admission from his outpatient psychiatrist is looking to transfer to a different team as he does not feel that he can repair the trust with the admitting team.

Help-Seeking

Once voluntary, participants reflected on how they would ask for help if they started to feel unwell. Several participants noted that help-seeking has improved over the years. Some cited that they have a better understanding of what happens when they become unwell and trust their outpatient team to help them make treatment decisions to keep them well. Participants demonstrated help-seeking in this way by reaching out to the team and being seen sooner. Others voice that they have been able to go to the ER when they are feeling unwell and request a voluntary admission to the hospital. Several participants stated that they would tell their outpatient health care team if they were noticing signs of illness. Some noted they would call their nurse or their psychiatrist. Others noted they would contact a family member, who could contact the team or the MHMCT. Participant 1 echoed the importance of calling on their health care team when symptoms of illness remerge, stating:

> I just rely upon a needle…It keeps me stable…Because I find that my schizophrenia acts up with me most of all when someone close to me dies…Like I had two cousins of mine die two months ago. I had to go to two funerals. And it was stressful on me. So right away I called my nurse, [nurse's name], and tell her I need an appointment with [psychiatrist]…I need to talk to her because the schizophrenia wants to come back. And I said, [Nurse], I said, 'Fit me in as fast as you can.' And which she did. She got me in. And I said, 'I've got to have my needle.' Thank God I had my needle (Participant 1).

Unfortunately, not all participants feel supported by their outpatient health care team despite active help-seeking behaviour. Participant 2 stated:

> Sometimes I ask [my team at the community mental health clinic], 'Can I talk to my [nurse or psychiatrist]?' But they never call me. I keep telling them, but they never call me (Participant 2).

Stigma

Participants did not endorse stigma as a reason for not seeking psychiatric care. Furthermore, stigma did not play a role in the participant's inpatient experience. Rather, participants reported the ability to be open about their illness while admitted involuntarily. It was after discharge from involuntary psychiatric care that participants started to think about how others view their illness and started to conceal their diagnosis and experience as an involuntary patient from others. Participant 5 stated:

> I kind of keep [my mental illness] to myself, unless like I'm asked. Because it's not really something you want to go and, you know, 'I'm manic depressive.'…To me, it makes me feel like now I'm less than. If that makes any sense…Like I'm not a whole person because I have a mental illness. Which is not the case. I know that…But like you can't help how you feel…If I went around telling everybody, you know, 'I'm a manic depressive' or 'I'm bipolar,' I feel like they would treat me differently somehow. And I don't want that…Like I don't want any extra attention. I don't want any less attention. It's like let me just…Do my thing. Get through my care. You know what I mean? (Participant 5).

Participant 3 reflected on the impact of being an involuntary patient has on his health care going forward, stating "[having an involuntary admission] puts a mark on your file like in the health system." Participant 6 reflected on how his acceptance of his mental illness has changed over the years. He relates this change to having good friends and more control over and insight into his symptoms.

Family

On reflection, several participants saw the overlap between familial issues and psychiatric symptoms. Participant 4 stated that leading to his first involuntary admission he was having a lot of conflict with his mother. I asked if he felt there could have been a better way that the family issues could have been delt with. He stated:

> Yes. But [the healthcare team] were basically ignoring [my family issues]. But a lot of the [family issues] do overlap [mental health] symptoms. And my paranoia [about my mother] is overlapped with the symptoms of psychosis. So, then they wouldn't be doing the job [if they didn't admit me] (Participant 4).

Of family issues, Participant 3 stated:

> I felt that [the admission] didn't really do too much in my situation at the time because I was dealing with long term [socioeconomic and family] stressors. You know what I mean? Like things that are still there as soon as I get out of the involuntary care, you know. So, I guess I feel like in that instance, that wasn't the best thing. Like maybe like a family intervention or something like that would have been better. And like even if like maybe there was like a black Nova Scotian who's a counsellor or a therapist or something that could have sat in on a family intervention." (Participant 3)

Community

Community played an important role in helping participants find their footing after involuntary psychiatric care. Participant 2 gave an example of how a woman took her into her home and helped her recover from her hospital stay. She stated:

> After I come out of [the hospital], I was five years I couldn't talk. [My illness] took my mind. It took my mind…But I met a Christian woman…And Jesus worked through her to help me get me on my feet…Like my mother knew of her from [hometown]…And then I lived up there for two years. And I just really… She really crunched Jesus in me. [laughs]. And it really helped. It really helped. Because for five years I couldn't talk…I just could just say yes or no or whatever. But my mind was gone. He took my mind. But then Jesus gave it back to me…Oh my gosh, if it wasn't for her, I would be still out of my mind (Participant 2).

Participants spoke of the importance of having people in the community to talk to about their experiences. Participant 3 stated:

> I'm connected with [The Black Brotherhood Initiative]. And so, I have someone there who I talk to about different stuff, who's there for me if I need someone to talk to, you know. But it's like before… Like in 2021, like I didn't have these things…I think it would have shifted a lot of things [if I had been connected prior

> to involuntary admission] (Participant 3).

Other community supports that the participants endorsed included friends, Peer Support, a Black psychologist, Metro Community Living, and their church congregation.

However, not all participants endorsed strong community supports. Participant 2 stated, “I’ve got Jesus, you know. But still, I’d still like to have somebody on Earth to talk to.” This experience was mirrored by Participant 4 who feels he does not have anyone in his community to help him with his anger or anxiety. He feels that he is “doing it on his own.”

The Health System

Participants shared that their trust of the health care team and health care system improved over time. This appeared to be due to periods of insight when participants were able to reflect on their periods of involuntary care and decide that their health care team had their best interests in mind during these times. Another important factor that increased participant trust in the health system having stable outpatient teams who they feel know their values and needs. Several participants had multiple involuntary admissions but did not endorse that this decreased their trust in the team. In fact, several participants felt that this increased their trust which was evident through their future help-seeking. Having a stable health care team over multiple years appeared to increase help-seeking and trust. Participants who had stable care teams reported feeling comfortable calling their team to inform them of onset of illness and were willing to see the team sooner to adjust treatment with the goal of avoiding involuntary admission. Participants with stable out-patient teams experienced trust and demonstrated help-seeking by voicing their preferences for treatment. When the participant's opinion was taken seriously it increased trust in the team. Participant 4 stated:

> The medicine that I was on was kind of strong. So, it ended up making me like kind of like zombie…made it so that I wouldn't talk to people or…Well, it was the fact of like it's a little bit…it's stronger than it should be. So [I asked my psychiatrist], 'can we reduce this down any, like the amount that I'm taking?' And [the psychiatrist] did…Then after the medication started getting regulated, it was like. Oh, wow, you know, I was messed up [during my admission] (Participant 4).

Socioeconomic Status

Participant 3 stated that his financial situation improved after involuntary admission through getting connected with social programming. He stated:

> Actually, because of [the admission and diagnosis], like it worked out in a way that I actually get assisted living right now for the next little bit. And so that's allowed me to like not really stress about money too much. Which was my main thing that I was stressed about. And like I have my education. I'm going to college. And my education is currently paid for. And so… And I'm back in class learning. And like my whole life is in a different state than it was during the pandemic in 2021. And a lot of my issues and needs got addressed (Participant 3).

Participants 5 and 6 spoke about the role of work after involuntary psychiatric care. When asked about working while having a mental illness, Participant 5 said things are going "pretty good." He stated:

> Like I said, nobody really knows I have a mental illness. So, it doesn't really play a factor in like how somebody's treating me. And I like it that way. It's kind of my own [business]… And I've been taking care of myself. Like if I wasn't taking care of myself then… Like I mean by getting a shot and like going into the hospital when the doctor wants to see me, when the psychiatrist wants to see me, then I feel like I'm getting through…and keeping well (Participant 5).

Participant 6 is on the job hunt. He stated:

> I'm not working right now. I have a lot of opportunities to do work because my

> resume was sent out. And a lot of people are like emailing me back saying that it was pretty nice, and it was pretty good, and they'd like to interview me and stuff… (Participant 6).

As all participants identified as Nova Scotia born, there was no intersection in experience with migration status. For female participants, no gender difference was reported. All participants identified as cisgendered and heterosexual. Participants did not identify any disabilities other than mental illness throughout the interviews.

Chapter 5: Discussion

In the following chapter the results from the current study will be discussed. The discussion will include lessons learned, recommendations to support Black Canadians who have experienced involuntary psychiatric care, and future research initiatives.

Lessons Learned

This primary researcher has many takeaways from the current research project and will focus on two lessons learned for the purpose of this discussion.

The first main lesson learned from this project is the essential role that trust played and plays in all aspects of caring for Black Nova Scotians who have experienced involuntary psychiatric care. The three primary areas where the need for trust was apparent was in the recruiting process for the current study, coming into involuntary psychiatric care, and continued engagement with the mental health system.

During recruitment, it was evident that trusting the primary researcher and her intentions was the deciding factor for participation. Some participants were familiar with the primary researcher through her various roles in Nova Scotia Health, and it was the trust that we had already developed during our working relationship that allowed the participant to agree to partake in the current study. Participants who had not met the primary researcher needed more time and explanation of the intentions of the study and the role of the primary researcher to feel comfortable in sharing their story. Aspects of the primary researcher's approach that aided trust in these relationships were consistency of her actions, transparency of the intentions of the study and the study's process, maintaining privacy and confidentiality, and the primary researcher's approach, which included being non-judgemental and validating the participant's experience.

Throughout data collection, themes of trust were evident in participants' narratives. Participants shared that trust was not only important due to their current experiences, but they also shared that trust, or lack of trust in the health care system, was connected to historical legacies of over-criminalization and pathologization of Black bodies in medicine and in the criminal justice systems. The narratives constructed with participants demonstrated the lasting impacts of slavery and colonialization and how these structures impact how and when African Nova Scotians seek help for their mental health concerns.

Trust was given to health care providers over time when the health care providers were able to provide consistent and culturally safe care. Participants trusted their teams when their preferences were considered, when they felt like their experiences were taken seriously, and when structural factors were contemplated (e.g., understanding the impacts that income and education has on one's mental health). This result demonstrates that culturally safe care can foster trust between African Nova Scotian client and health provider. This primary researcher will integrate these lessons into her own practice and share these takeaways with her colleagues within the Mental Health Program at Nova Scotia Health.

The second lesson learned pertains to being a White researcher attempting to engage Black Nova Scotians. There is an existing power imbalance between researcher and participant which is further amplified when the researcher is White. This power imbalance was evident to the primary researcher was attempting to recruit participants through churches. Of the church leaders contacted, only one responded to the request to discuss the current study. The primary researcher recognizes the historical legacies of over-researching specific populations, leading to further marginalization at the hands of White academics. A lesson learned from this experience is the importance of relation building with community agencies to build trust. Further, developing deliverables that leave communities with positive initiatives is essential in working with groups that have been over-researched and abused by the academy. Another important aspect for future research is bringing in community members as research assistants on projects about their own communities. This not only boosts the economy of the community, but it also adds essential knowledge to the study that the primary researcher, as a White settler, does not have, further boosting the rigor of the project. Based on these lessons learned and the findings of the study, the primary researcher also offered systemic recommendations aimed at improving the experience of Black Nova Scotians who have experienced involuntary psychiatric care.

Recommendations

Based on the findings from the current study and other literature that offers evidence-informed strategies for supporting Black Canadians who have experienced involuntary psychiatric care, the primary researcher puts forth the following recommendations:

- The primary researcher first calls on the Provincial and Federal governments to enact structural changes to address the underlying structural causes of involuntary psychiatric care.

- Prioritize the creation of a Black Nova Scotian Pathway of Care for people of African descent entering the mental health system.
- Reduce the gap between outpatient and inpatient services for diverse Black Nova Scotians.
- Improve resources for the Mental Health Mobile Crisis Team to help decrease the reliance on police.
- Improve the physical environment of the Psychiatric Emergency Service and inpatient units.
- Provide training for mental health staff for caring for diverse Black Nova Scotians.

The following recommendations will be discussed further below.

Recommendation: The primary researcher calls on the Provincial and Federal governments to enact structural changes to address the underlying structural causes of involuntary psychiatric care.

In the current study, the intersection between race, illness, and socioeconomic status was significant for Black Nova Scotians under involuntary psychiatric care. Poverty is stressful for individuals and families, and this stress can contribute to the development of psychosis. Being in the hospital also causes and reinforces poverty. Income assistance is significantly reduced when a person is in care. Furthermore, housing placement through the Department of Community Services can be revoked or reclassified when someone is in care, leading to homelessness on discharge from the hospital. Historic and current structural policies, shaped by anti-Black racism, have placed, and kept, African Nova Scotians at a higher rate of poverty, making Black Canadians more likely to experience poverty and its effects for multiple generations compared to White Canadians (Schimmele et al., 2023). These structural factors include racism, colonialism, and enslavement (Hamilton-Hinch & MacVicar, 2022). Systemic factors reinforce existing hierarchies of privilege and work to oppress, keeping those marginalized by race, ethnicity, gender, sexual orientation, disability, and age in poverty. The racism embedded in health and social policies becomes normalized, further strengthening inequity over generations (Hamilton-Hinch & MacVicar, 2022).

People living in poverty, especially those who have experienced generational poverty, are less likely to have sufficient savings to support themselves in the hospital or if unable to work due to illness. Furthermore, Black Canadians are more likely to be unemployed compared to other racialized Canadians despite this group having the highest participation rate in the Canadian labour market (Block et al., 2019). Discrimination against Black Canadian workers arises in the labour market as factors such as the employer's failure to recognize foreign education and credentials, the narrowing of immigrant employment programs by the federal government, and ongoing exclusion from high-paying jobs, with worsening employment discrimination and exclusion for Black women and gender non-conforming, 2SLGBTQ+, disabled, aged, and migrant Canadians (Maynard, 2017). Canadian wage discrepancies continue to have racial and gender differences; Black men are making $0.66 for every $1.00 that a White man makes (Block et al., 2019). A Black woman will take home $0.83 compared to her White counterpart, and White Canadian women continue to make $0.56 for every White man's dollar (Block et al., 2019).

Despite having higher educational achievement, Black Canadian women are more often underemployed compared to White women (Foster et al., 2021). Therefore, if a Black Canadian must take time off work for involuntary hospitalization or mental health treatment, they are more likely to be negatively impacted by wages lost.

Underemployment and working in non-standard jobs (e.g., part-time, casual, or temporary jobs, "gig economy" jobs, or jobs without extended health care benefits) may result in people not having health benefits when they cannot work due to illness. Racialized Canadians, especially racialized women and gender non-conforming people are more likely to work in non-standard jobs, such as childcare, contract teaching jobs, and non-unionized jobs (Ivanova & Strauss, 2023).

The Nova Scotia Labour Department currently supports three unpaid sick days a year and mandates no doctor's notes for leaves less than five days (Nova Scotia, 2024). However, this would not be relevant for most people who are admitted involuntarily to a psychiatric unit, as these stays can last weeks to months. Canadians are eligible for Employment Insurance (EI) sickness benefits after one week of illness, but only if they have worked at least 600 insured hours in the previous year. Many people who have chronic mental health concerns have not garnered sufficient hours to draw EI either due to gaps in employment or working in jobs that do not qualify for EI (i.e., unpaid or under-the-table work like childcare or manual labour), leaving them without formal sick benefits.

Additionally, EI only pays 60% of one's income, which is insufficient to support most people, especially the groups listed above. If an individual cannot work full time and does not have private insurance, they could be eligible for Nova Scotia income assistance and Canada Pension Plan Disability. In 2022, Nova Scotia residents who had a disability, were single, and with no children received an annual income of $12,687 (Maytree, 2023). The Canada Centre for Policy Alternatives states that a wage of $26.50 an hour ($55,120 annually[6]) is required to live safely and comfortably in Halifax, Nova Scotia (Saulnier, 2023). Therefore, for Black Nova Scotians who are at risk for involuntary psychiatric admission, the current social safety net does not adequately provide support. Within the Minority Stress Theory, poverty and involuntary psychiatric admission are distal stressors that, along with the intersection of race and other held identities, such as gender, contribute to the development of illness. Policies need to be put in place that prioritize improvements in living conditions for Black Nova Scotians and, thus, the health outcomes of this group.

In 2022, the Nova Scotia government showed their commitment to elevating racialized Nova Scotians by putting through the *Dismantling Racism and Hate Act* (2022) and creating the *Health Equity Framework* (2022). However, the primary researcher believes that more needs to be done to structurally support the wellness of diverse Black Nova Scotians living with mental illness. The first step would be for the federal

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[6] The Annual salary is the primary researchers' own calculation to illustrate the difference between what is provided to people on social assistance and what is required to live comfortably in Halifax, Nova Scotia. The annual salary is based on working 40 hours a week, 52 weeks a year.

government to implement a guaranteed livable income for all Canadians. Robust research shows guaranteed livable income boosts recipients' health (Pate, 2020). Additionally, all Nova Scotians should be granted sick leave. Government-supported sick days have already been enacted for federally regulated workers and some provinces (Canada, 2022). Advocacy groups call for ten paid sick days annually for all Nova Scotians (Nova Scotia Federation of Labour, 2023). For people at risk for involuntary admission, a paid sick day could allow time to connect with their outpatient team, adjust medication, or seek emergency support without fearing losing income or their position due to absenteeism.

Along with supported income, the government should continue to increase funding for Black Nova Scotian-led organizations, as the most relevant and meaningful change comes from members of the target community; funding Black organizations pushes back against the Whiteness that makes up many of the larger non-profit organizations (Danley & Blessett, 2022). African Nova Scotians are taking charge of the health of their communities where governments are lagging or lacking. Examples of this leadership are groups like the Upper Hammonds Plains Community Land Trust, where the community is coming together to provide affordable and secure land ownership to Black residents (UHPCLT, 2024), the Health Association of African Canadians, which engages the community in health promotion and prevention (HAAC, 2024), Hope Blooms, who delivers experiential learning and scholarships for African Nova Scotian youth, One North End, who has services like providing micro-loans to African Nova Scotian entrepreneurs (One North End, 2022), and the Black Cultural Society, a hub for

Black art, music, and education (BCC, 2024). These organizations, and many more, make a vital difference in the lives and health status of African Nova Scotians by fostering community, buffering stress, and providing education and opportunities, and therefore, must be supported financially by governments to nurture good health for Nova Scotians of African descent.

Recommendation: Create a Black Nova Scotian Pathway of Care.

Black Nova Scotians who have experienced involuntary psychiatric care have distinct needs that are not being met in the current mental health care system. How this group decides to seek help and when to trust the healthcare system needs special consideration. The findings from the current study show that for diverse Black Nova Scotians, trust and help-seeking are interconnected in the periods leading to, during, and after involuntary psychiatric care. To support this group through the involuntary mental health care system, the primary researcher proposes a Black Nova Scotian Pathway of Care that is enacted at the initial point of contact when a Nova Scotian of African descent connects with mental health services. The pathway would continue throughout their contact with inpatient and outpatient mental health services, including community agencies and spiritual care. It would also include preventative psychoeducation for family members and community leaders to increase health promotion and decrease stigma.

The first consideration of this pathway is the involvement of family members. Research shows that family-centred care is essential to improving outcomes for racialized patients (Ofonedu et al., 2023). In the African Nova Scotian context, the family includes the nuclear family and extended family members (Thomas Bernard & Bonner, 2013). However, non-related family members also provide support within the African Nova Scotian community. “The creation of extended kinship networks…” including grandparents, aunts, uncles, cousins, and non-related community members “…served to enhance an ethic of care within the small, oftentimes geographically isolated and racially segregated communities” (Thomas Bernard & Bonner, 2013, p. 165). The development of extended kinship networks is theorized to be based on African tradition, but it also served as a protective factor during enslavement when biological families were often separated (Thomas Bernard & Bonner, 2013). In the present study, family members were the leading players in encouraging trust and help-seeking for Black Nova Scotians, and therefore, the Black Pathway of Care starts with providing education and support to this group.

Nova Scotians of African descent proxy their family members’ trust and help-seeking as their own; if their family member encourages them to connect with services, they are more likely to attempt to accept mental health care. Female family members of Black Nova Scotians are vital for identifying subtle changes in the mental status of their kin and are essential in connecting their family members to mental health support. While admitted, family members are essential in helping Black Nova Scotians under involuntary care trust the inpatient team. Therefore, the inclusion of family, especially female family members, is necessary for the success of caring for Black Nova Scotians who access mental health care. Therefore, the first step in the Black Nova Scotian Pathway of Care is psychoeducation for family members. The goal of this psychoeducation would be to increase awareness of the signs and symptoms of mental illness for improved prevention and early intervention and to decrease the stigma of mental illness.

For Black North Americans, having a mental illness is often accompanied by individual stigma, with thoughts that psychiatric illness means weakness of mind, faith, or character (Aden et al., 2020; Waldron et al., 2023). Stigma leads to reduced help-seeking for mental health concerns (Waldron et al., 2023) and increased isolation within one's community (Alang, 2016; Hatzenbuehler et al., 2013). In the current study, participants shared that family members did not want to visit them in the hospital because they feared the other patients were dangerous. Family members also voiced that more faith and prayer were needed to help the participants heal from their illnesses. Therefore, the results of this study show that interventions related to stigma should occur at the individual, family, and community levels before involuntary hospitalization.

Tam (2019) shared action-based interventions to reduce stigma at each level of stigmatization: individual, interpersonal, institutional, and population levels. The two levels in which participants in the current study reported stigma were individual and interpersonal. Therefore, this author recommends using interventions by Tam (2019) to intervene at these levels. At the individual level, Tam (2019) recommends support groups focused on psychoeducation, teaching coping skills, and building support networks. At the interpersonal level, intervention would be focused on education about mental illness to increase understanding of mental illness (Tam, 2019). However, this education must be specific to the needs and realities of the African Nova Scotian population. Gibbs et al. (2022) found that providing culturally competent psychoeducation that factors into the racial experience for Black caregivers for family members with schizophrenia increases engagement for this group. Therefore, psychoeducation for African Nova Scotians would be best integrated into the community by trusted community members who understand the dynamics of specific neighbourhoods with subject matter that speaks to the intersection of race and mental illness.

A second important area for psychoeducation is the school system. Participants in the current study identified the role of the school system in the development and experience of psychosis. Participants shared that being a Black child in a predominately White classroom is stressful and stigmatizing, particularly when learning about the history of slavery. How Black Nova Scotian students received information about slavery from White teachers felt othering, leading to stigmatization from self and their classmates and increased stress load. This experience is just a snapshot of what it is like to be a Black student in a White supremacist school system. Maynard (2017) states, "historically, Canada's public education system has been an explicit tool towards the advancement of White supremacy, and public schools have been a site of both abandonment and captivity for Black youth" (p. 212). Maynard (2017) is, of course, referring to the long history of segregating Black students formally (in their underfunded schools) and informally (by the overrepresentation of Black students in lower educational tracks), as well as the overt discrimination and "pushing out" faced by Black Canadian students through higher levels of suspension, expulsion, and neglect compared to their White peers (Maynard, 2017). Therefore, it would be remiss of a Black Nova Scotian Pathway of Care not to include the educational system.

Strides have been made in Nova Scotia to support the educational experience for people of African descent. Programs such as the new Africentric Bachelor of Education (B.Ed.) program at Acadia University (Acadia University, 2024) and the Africentric Offering of the Early Childhood Education program at Nova Scotia Community College aim to attract and support racially diverse educational professionals. In Nova Scotian schools Africentric cohorts have been introduced with excellent feedback from students and educators (Halifax Regional Centre for Education, 2018). The Nova Scotia School Board also introduced the African Nova Scotian Education Framework (Nova Scotia, 2021). However, psychoeducation regarding aimed at reducing the stigma around mental health in the African Canadian communities would be essential for supporting Black students.

Within the health care system, the Pathway would also be initiated by staff once the individual or their family contacted the MHMCT or presented to the Emergency Department for assessment. The guide would provide psychoeducation to patients and staff regarding culturally specific considerations for Black patients experiencing symptoms of mental illness. Once admitted, this guide would include information on connecting patients with staff from the Nova Scotia Brotherhood and Sisterhood. Staff from these groups would meet with patients and help advocate, provide education to patients and staff, and help set up connections for after discharge. The Brotherhood and Sisterhood have been doing this work already, however, staff on the inpatients units are not fully aware of the services that the Brotherhood and Sisterhood can provide. Further, these groups have small numbers of staff, and may not be able to visit all Black patients who are involuntarily admitted. Along with community resources, the pathway would provide the option for culturally safe spiritual guidance for Black involuntary patients. Participants spoke of fear and loneliness in the hospital, and voiced that spirituality was a helpful coping mechanism after discharge but did not know about the spiritual resources while on the unit. Despite Nova Scotia Health having a Spiritual Care service, it is not commonly accessed by inpatient psychiatric units. Having spiritual care available for on-unit visits would be an essential offering for involuntary patients who may not have access to passes off the unit during their admission. Finally, after discharge, the team would attempt to match the patient with a clinician or psychiatrist of African descent. One participant stated that he would have even opted to see a psychiatrist over telehealth if it meant that the psychiatrist was Black.

The journey of diverse Black Nova Scotians through involuntary psychiatric care is marked by unique challenges and nuanced needs that are often unmet within the current mental health care system. Trust and help-seeking behaviours are deeply intertwined in the decision-making process for this community, emphasizing the crucial role of family involvement and culturally sensitive support mechanisms. A tailored Black Nova Scotian Pathway of Care is proposed to address inequities in the pathway to involuntary psychiatric care, beginning with comprehensive psychoeducation for family members and extending throughout the entire continuum of mental health services. This pathway encompasses community engagement, educational reform, and enhanced support structures, aiming to foster trust, reduce stigma, and provide culturally safe care at every stage of the mental health journey. By centring the experiences and needs of

Black Nova Scotians, this holistic approach seeks to bridge the gaps in the current system and promote equitable access to effective mental health.

Recommendation: Reduce the gap between outpatient and inpatient services for Black Nova Scotians.

The results of this study show that for African Nova Scotians who have undergone involuntary psychiatric care, help-seeking is time sensitive. The period between initial help-seeking, like family members calling crisis services (the Mental Health Mobile Crisis Team, police, or Emergency Medical Services) and the time in which they are assessed by a psychiatrist is when trust and help-seeking diminishes. Because of long wait times to be assessed by a psychiatrist in Psychiatric Emergency Services (PES), symptoms of illness in Black Nova Scotians progress to a level where insight has decreased and trust and help-seeking are absent, leading to involuntary psychiatric admission. Similarly, Smith et al. (2023) found that Black Americans voluntarily attended the emergency department for mental health concerns but were subsequently admitted involuntarily (Smith et al., 2023). Therefore, this time window is a critical intervention point for providing treatment. The experience of worsening insight into one's symptoms is a hallmark of psychotic illness and one of the main factors that leads to admission under involuntary psychiatric care (Belvederi & Amore, 2019; Rodrigues et al., 2019).

For Black Nova Scotians in the current study, presenting voluntarily to PES with symptoms of mental illness does not always lead to a voluntary admission, even when family is advocating for an admission to hospital. This group reports that at these times they were deemed too well to be admitted to the hospital and that they should follow up with their community team or general practitioner. However, folks may not follow up with community care due to lack of trust or lack of availability and then decompensate to the level that they would be admitted involuntarily. The phenomena of people with mental illness stuck between being too sick to be managed in the community and too well to be admitted to the hospital is a reality in the current psychiatric system (Heekeren et al., 2020). Due to bed shortages, people with psychiatric symptoms that could benefit from an admission may be turned away to follow up with community care or boarded in the emergency room (ER) due to lack of beds available to voluntary patients. If symptoms reach the threshold for admission but there are no inpatient beds available, admission to a "virtual bed" in PES is sometimes considered. Despite "boarding" in the ER being a detrimental practice for patients and staff (Nordstrom et al., 2019), these patients may be too acutely unwell to be managed in a traditional out-patient clinic setting, and thus cannot be discharged from the ER.

Intermediate psychiatric services such as psychiatric day hospitals can be a cost-effective and appropriate level of treatment for this group (Heekeren et al., 2020). A 10-bed, voluntary acute psychiatric day hospital was opened in Nova Scotia in 2022 (Nova Scotia, 2022). None of the participants in the current study had experience with the Mental Health Day Hospital as it was not open at the time of their involuntary care, however, it is the opinion of the primary researcher that some of their involuntary admissions could have been avoided if they were given timely access to a bed in the Mental Health Day Hospital.

Timely intervention during the critical window between initial help-seeking and psychiatric assessment is essential for African Nova Scotians navigating involuntary psychiatric care. Long wait times and gaps in care contribute to worsened insight and trust issues, emphasizing the urgent need for accessible, culturally sensitive treatment options like psychiatric day hospitals.

Recommendation: Improve resources for Mental Health Mobile Crisis Team to help decrease the reliance on police.

Presently, the police are a common aspect of the pathway to involuntary psychiatric care. Research has shown that Black Canadians are more likely to encounter police and crisis services in their pathway to involuntary psychiatric care (Cénat et al., 2023) and contact with police has often resulted in injury or death for Black people with mental illness (Waldron, 2020). In the current study, police were involved in the events leading to involuntary psychiatric care for all participants, and past experiences with the police and the justice system were found to result in decreased trust in the mental health care system. Therefore, it is essential to examine the role of police in the assessment and transport of Black Nova Scotians with mental illness.

Currently, under the Involuntary Psychiatric Treatment Act (IPTA) (Province of Nova Scotia, 2015), police can transport individuals against their will if the officer believes that they would meet the criteria for an involuntary psychiatric assessment. Crisis services in Nova Scotia, such as the Mental Health Mobile Crisis Team, have police officers on their team to hold and transport individuals under IPTA. These officers receive specialized training to assist in mental health calls (Kinsella, 2023) and are accompanied by MHMCT clinicians (employees of Nova Scotia Health).

However, for the African Nova Scotian community, the presence of a police officer is often not comforting and can cause more distress. Furthermore, MHMCT's resources are often stretched. Thus, outpatient psychiatrists and mental health clinicians rely on the police to intervein in the community if the outpatient team has concerns for the safety of their patient (e.g., the psychiatrist believes that the patient would meet the criteria for an involuntary assessment, and they would like the police to take this person to PES). The need for police in the current process is unavoidable, but increasing funding to MHMCT would decrease the number of police-led mental health calls.

With the prevalent role of police in facilitating involuntary psychiatric care, particularly concerning Black Canadians in Nova Scotia, this is an essential area for further investigation and intervention. Thus, while police intervention remains unavoidable in the current process, enhancing mental health resources could mitigate their involvement in mental health crises.

Recommendation: Improve the physical environment of the Psychiatric Emergency Service and inpatient units.

The physical environments of mental health facilities are essential for promoting recovery (Gupta et al., 2024; Karlin & Zeiss, 2006); however, they have the potential to increase aggressive behaviour in patients, leading to increased seclusion and restraint use (Ulrich et al., 2018). The two main areas involuntary patients frequent are the Psychiatric Emergency Service and the inpatient unit.

Waiting in PES with symptoms of psychosis or mania is confusing, uncomfortable, and fear-inducing for Black Nova Scotians due to confusion about the process in the system or due to thought disorganization secondary to illness. For Black Nova Scotians in the current study, being held for assessment in the PES felt carceral. A study with Black Americans who experienced involuntary psychiatric care shared similar experiences, stating that the process of involuntary care felt criminalizing and vulnerable (Smith et al., 2023). In 2023, the psychiatric assessment suites at the QEII Charles V. Keating Emergency and Trauma Centre underwent a $450,000 renovation funded by the QEII Health Science Centre Foundation charity (Topple, 2024). These upgrades include three treatment rooms, an isolation area and a nurses' station, dimmable lighting for the first time, soundproofing, windows to allow natural light (Topple, 2024), and comfortable weighted furniture (Topple, 2022). These changes to the built environment are congruent with the recommendations in the literature to aid relaxation (Gupta et al., 2024) while maintaining staff and patient safety (Holms et al., 2020; Karlin & Zeiss, 2006).

Spatial concerns raised by participants in the current study included isolation from family and the outside world, boredom in the unit, perception of staff unavailability, and lack of private space. These concerns have been identified in other studies and are contradictory to recovery, erode staff-patient trust (Holmes et al., 2020), and can increase seclusion and restraint use (secondary to increased aggression) (Ulrich et al., 2018). In their study of the impact that physical environments have on patients in mental health units, Holmes et al. (2020) found that the reduction of physical barriers between patients and staff (i.e., glass around the nursing station or nursing stations that are removed from the milieu of the unit) increase patient trust in unit staff, increased feelings of dignity, and promoted a sense of reality.

Single rooms are preferred over dormitory-style rooms (Karlin & Zeiss, 2006) to increase privacy and decrease stress (Ulrich et al., 2018). However, this is not the case in the current psychiatric inpatient units within Nova Scotia. The majority of patient rooms have two or three beds per room. Roommates are matched on gender, and staff attempt to arrange rooms to suit the needs of the patients (e.g., putting people with similar needs or schedules together), but planning is often hindered by units being at maximum capacity.

Conversely, the youth mental health inpatient unit at Garron Centre boasts the design qualities mentioned above, including a central nursing station, single rooms, and multiple public quiet areas for patients and their families to rest or meet with staff (Architecture49, 2014). It is time for the adult inpatient mental health units to follow suit.

Recommendation: Provide training for mental health staff for caring for diverse Black Nova Scotians.

Although the Black Nova Scotian population is not a monolith, the current model of care devised from colonialist and White-supremist ideals does not consider the unique needs of Black Nova Scotians. Thus, changes to how health care providers are educated and provide care are needed to ensure the optimal health of Black Nova Scotians and is targeted at nurses and allied health professional. This education would be guided by an Africentric framework like the one presented by Este and Thomas Bernard (2019). The four main pillars of this model are: the interconnection of all things, collective identity, affective dimension, and the spiritual nature of human beings. Each of these concepts will be discussed below with recommendations of how we can begin to integrate these concepts into mental health care.

First is the interconnection of all things. This concept embraces the idea that human beings are connected to all things in their environments, sees relationships with family and community as essential to sense of self, prioritizes interpersonal relationships and necessary in building hope for the future, and collective identity, meaning that an individual cannot be understood on their own, but only in connection to their wider group (Este & Thomas Bernard, 2019). For Black Nova Scotians experiencing involuntary psychiatric care, this concept could be actualized as health care teams taking the time to understand the patient as a part of their wider family and community system. Nurses are oriented to create interpersonal relationships with their patients. The nurse can work to understand what the client wants for their future and foster hope for this future. She can also work to connect the client with community resources that can help the client to continue to build collective identity.

The second concept of an Africentric worldview is collective identity. This is the idea that individuals cannot be understood on their own, but only in connection to their wider group. Collective identity also prioritizes responsibility for other community members, respect for elders, and the idea of the community, rather than the parents alone, raising the community's children (Este & Thomas Bernard, 2019). On the unit, the nurse can foster this idea by building community between patients. Once the client can leave involuntary care, she can work with the client to set up and re-establish connections within the community. In the outpatient setting, the team can encourage the client to include their family and community in their care decisions. When focusing on rehabilitation, the nurse can help the client explore taking on responsibility for their community through volunteering.

The third idea of an Africentric worldview is the affective dimension. This idea stresses the balance and interconnectedness between emotions and rationality and sees emotional experience as essential to understanding someone's experience (Este & Thomas Bernard, 2019). Emotions can be honoured at all points of the care pathway through giving space for the client to express their emotions about their experiences. Asking questions about their affective experience will allow for the nurse and team to validate the emotional aspects of their journey.

Finally, Este and Thomas Bernard (2019) note spirituality as essential to Africentrism. The spiritual nature of human being, they state, is essential for balance. Spirituality, understood through an Africentrism lens, is in opposition to Eurocentric materialism, and when spirituality is expressed, one fully experiences self-worth, peace, value, and purpose (Este & Thomas Bernard, 2019). The care team can refer the client to Spiritual Care while on the inpatient unit. However, spirituality also recognizes balance and peace. Nurses can encourage the client to reflect on their experiences and try to find meaning to find peace. The nurse can reflect the client's worth and value. She can encourage the client to connect with whatever Higher Power brings them comfort.

The above discussion outlines recommendations for addressing the structural causes of involuntary psychiatric care among Black Nova Scotians. It highlights the intersectionality of race, illness, and socioeconomic status, emphasizing how poverty, discrimination, and historical injustices contribute to mental health disparities. Structural changes at the provincial and federal levels are needed to support Black Nova Scotians, including implementing a Black Nova Scotian Pathway of Care. This pathway emphasizes family involvement, psychoeducation, community support, and culturally sensitive interventions throughout the mental health care journey. Additionally, recommendations are made to improve resources for the Mental Health Mobile Crisis Team, enhance the physical environment of psychiatric facilities, and provide training for nurses and allied mental health professional to serve diverse Black Nova Scotians better. Overall, the proposed interventions aim to address systemic inequalities and promote equitable access to effective mental health care for Black Nova Scotians experiencing involuntary psychiatric care.

Future Research Initiatives

Upon reflection of the results of the current study, there are two main areas that the primary researcher would like to expand upon in future research. First, the primary researcher hoped to interview participants with a variety of intersecting identities to begin to understand the nuanced layers of diverse Black Nova Scotians who have experienced involuntary psychiatric care. However, all participants in the current study African Nova Scotian, meaning all participants identified as being descendants of people who have lived in Nova Scotia for multiple generations and are a part of historic Black communities within HRM. The results gathered lack the intersectional experience of what it means to be a Black immigrant to Nova Scotia. Furthermore, all participants identified as cis-gendered and heterosexual. Again, the intersections of diverse gender and sexual identity would have added another level that has yet to be explored in the literature on African Nova Scotians who have experienced involuntary psychiatric care. Further studies targeting Black migrants to Nova Scotia and people of diverse gender and sexual orientations are necessary to further understand the distinct experience of being Black and mentally ill in Nova Scotia.

A second area of further research would be interviewing families and community members connected to diverse Black Nova Scotians who have had involuntary psychiatric care. Hearing from these groups would be essential when planning and implementing psychoeducational initiatives in the community, such as those described in the recommendation regarding a Black Nova Scotian Pathway of Care. Furthermore, involving family and community expands the knowledge of this concept, reduction of insight into one's illness on the part of the participant is often present in the pathway to involuntary psychiatric care. To understand the full story of how a participant ended up involuntarily admitted it would be important to speak to the other players in the narrative. Another imperative reason to involve family and community in future research is to honour the Africentric principle of the interconnectedness of all things (Este & Thomas Bernard, 2019). This tenant states that an individual is not fully understood unless the family and community are also considered, and therefore, must be studied as a part of decolonizing mental health care in Nova Scotia.

Chapter 6: Conclusion

Canadians often delight in the illusion that racism does not exist in our country, but scholarly literature and Black Canadians' personal experiences disprove this myth (Block, Galabuzi, & Tranjan, 2019; Lawson, 2020; Maynard, 2019; Rankin, 2020). The history of psychiatry is built on racist and White supremacist ideologies that have overtly harmed Black North Americans (Washington, 2006). In recent years, the harms have become more covert, but psychiatry continues to work in close connection with the carceral system and policing, resulting in a nuanced and often harmful experience for Black Canadians. The current study aimed to explore the experiences of Black Nova Scotians who have experienced involuntary psychiatric care, and the narratives collected were examined using an intersectional framework and Minority Stress Theory. Through using a narrative approach, six Black Nova Scotians who experienced involuntary psychiatric care were interviewed. The recommendations provided in the discussion chapter highlight the need for a specific Black Nova Scotian mental health pathway to optimize an Africentric approach to mental health care, as well as fundamental changes in the way that governments support Black Canadians with mental illnesses. Further research directions should focus on implementing these recommendations to improve the access and experiences of Black Nova Scotians with mental illness.

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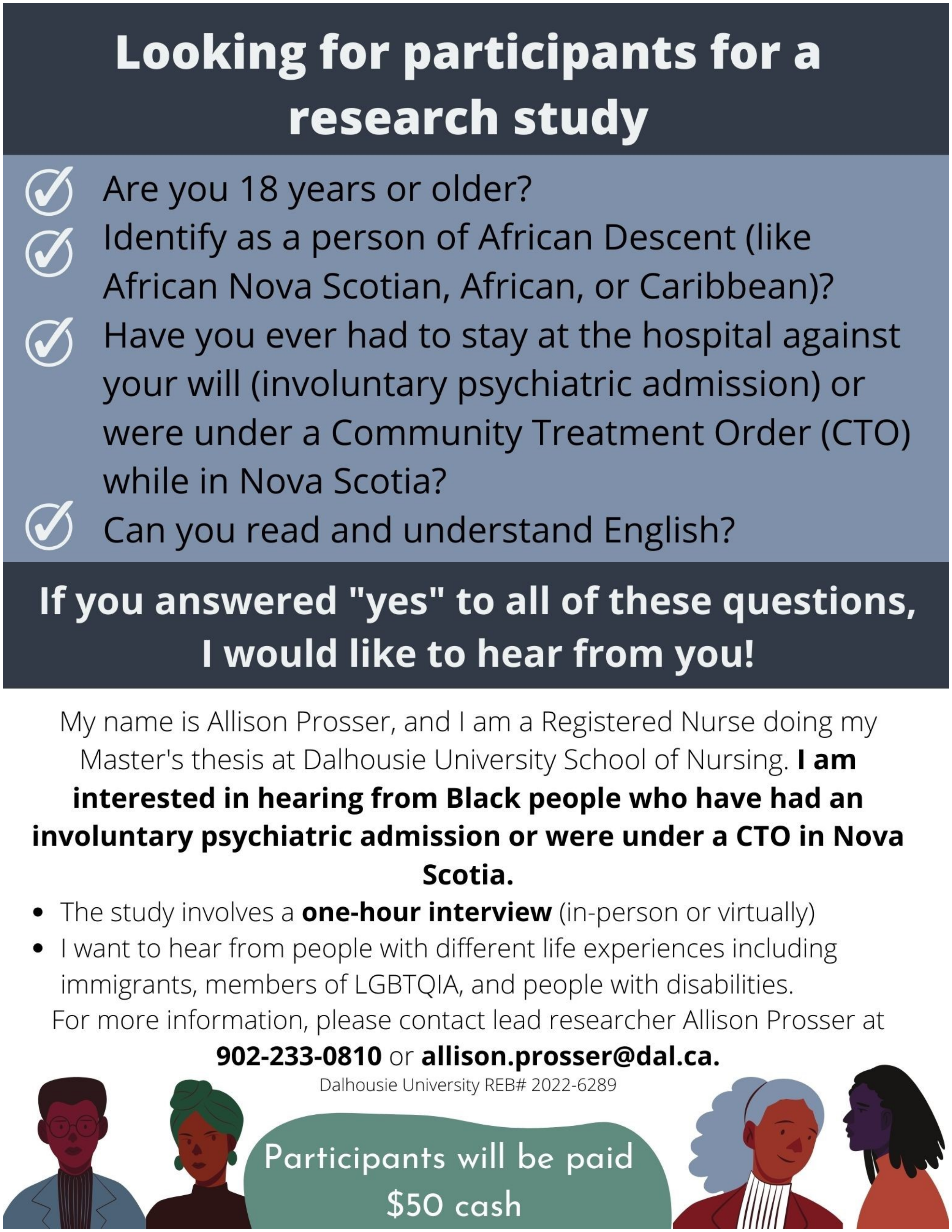
Appendix A: Recruitment Poster



Looking for participants for a research study

- ✓ Are you 18 years or older?
- ✓ Identify as a person of African Descent (like African Nova Scotian, African, or Caribbean)?
- ✓ Have you ever had to stay at the hospital against your will (involuntary psychiatric admission) or were under a Community Treatment Order (CTO) while in Nova Scotia?
- ✓ Can you read and understand English?

If you answered "yes" to all of these questions, I would like to hear from you!

My name is Allison Prosser, and I am a Registered Nurse doing my Master's thesis at Dalhousie University School of Nursing. **I am interested in hearing from Black people who have had an involuntary psychiatric admission or were under a CTO in Nova Scotia.**

- The study involves a **one-hour interview** (in-person or virtually)
- I want to hear from people with different life experiences including immigrants, members of LGBTQIA, and people with disabilities.

For more information, please contact lead researcher Allison Prosser at **902-233-0810** or **allison.prosser@dal.ca.**

Dalhousie University REB# 2022-6289

Participants will be paid $50 cash

Appendix B: Telephone Script

If the participant has left me a message asking for more information and/or a call back I will start with:

"Hello, may I please speak with [insert the name of potential participant here]?"

- *If the potential participant is not home, I will ask if there is a better time to call. I will not leave a message as I do not want to disclose a potenial participants interest in the study. If they are home, continue with the conversation*

"Hi, [insert the name of the potential participant here] this is Allison Prosser calling from Dalhousie University School of Nursing. I am conducting research under Dr. Ingrid Waldron and Dr. Jean Hughes."

"I am calling today because you expressed interest in my research study that we are conducting. The study is being conducted by myself, Allison Prosser, a master's student at Dalhousie University and will look at the experiences of Black Nova Scotians with involuntary psychiatric care. Would you be interested in hearing more about this study?"

- *If person says "No", thank them for their time. State:* "I have a list of mental health and addiction services in Nova Scotia that I can send you by email. Would you be interested?"*, if yes, collect proceed to send email. Thank them again, and say good-bye.*
- *If person says "Yes", I will continue with the script.*

[Study description] **"Great, let me tell you about my study. I am doing this study because I want to hear the stories of Black Nova Scotians who have had an involuntary psychiatric admission. In other words, they have been in the hospital against their wishes. I am collecting your stories to understand your experiences in**

the hospital as a Black Nova Scotian. I hope to talk to 20-25 people about their experiences. Is this something that you might be interested in helping me with?"

- *If person says "No", thank them for their time. State:* "I have a list of mental health and addiction services in Nova Scotia that I can send you by email. Would you be interested?"*, if yes, collect proceed to send email. Thank them again, and say good-bye.*
- *If person says "Yes", I will continue with the script.*

[Eligibility screening] **"To make sure you are a good fit for my study, can I ask you a few questions?"**

- *If person says "No", thank them for their time. State:* "I have a list of mental health and addiction services in Nova Scotia that I can send you by email. Would you be interested?"*, if yes, collect proceed to send email. Thank them again, and say good-bye.*
- *If person says "Yes", I will continue with the script.*

"Are you 18 years old or older? [must answer "yes"]

What is your ethnicity? [must answer "African/Caribbean/Black Nova Scotian, African/Caribbean/Black Canadian, Black, African, or Caribbean", or other Black ethnicity, i.e., Nigerian, Ethiopian, mixed/biracial/multiracial]

Have had at least one stay in the hospital where you were involuntary (against your wishes) in Nova Scotia or were under a Community Treatment Order in Nova Scotia? [must answer "yes"]

Are you currently in the hospital involuntarily? [must answer "no"]

Are you currently on a CTO (a community treatment order)? [must answer "no"]

Can you read and speak English?" [must answer "yes"]

- *If they fit the screening criteria, proceed study requirements.*
- *If they are currently under involuntary care (admission or CTO), thank them for their time, and tell them that they may contact the writer when they are no longer under involuntary psychiatric care if they want to participant in the study. State:* "I have a list of mental health and addiction services in Nova Scotia that I can send you by email. Would you be interested?"*, if yes, collect proceed to send email. Thank them again, and say good-bye.*
- *If they do not fit one of the other screening criteria, explain that that do not fit the criteria, thank them for their time. State:* "I have a list of mental health and addiction services in Nova Scotia that I can send you by email. Would you be interested?"*, if yes, collect proceed to send email. Thank them again, and say good-bye.*

[Participant time and action requirement] **"You fit all of the criteria for this study, so let me tell you what taking part in this study would look like."**

Say:

- **We would arrange to have a 1-hour interview with me on the in-person or on Microsoft Teams. Microsoft Teams is a free software that can be installed on a computer or smart phone. To meet on Teams, you would need to have a private space where you cannot be overheard to have this conversation.**
- **If we meet in person, you will pick where we meet from a list. These places are private rooms at a library or community centre all around the province. I want you to pick a place that works best for you.**
- **During this interview I will ask you questions about your time in the hospital. I will ask you questions about the time before and after you were taken to the hospital. You can tell me as much or as little as you'd like. Your participation is completely voluntary, and you can stop the interview at any time and still be paid.**
- **After we finish our conversation, I will send you a written copy of what you said. I will send this to you through a program called OneDrive. You can let me know if you want anything changed or removed that makes you uncomfortable or that you think will let people know that you were a part of this study.**
  - **I will respect your privacy in this study and will not include your name in the final study report. For example, I will take out any details that might let others know your identity.**
  - **Once you look over this document, we can talk on the phone or on Teams if you have any changes that you want me to make. Reviewing this document will take 20 minutes to 1-hour.**
- **You will be paid $50 for your time. You will be paid even if you do not finish the study.**

- **If you would like to receive a copy of the final study, you can let me know and I will send you a copy once it is complete.**

Ask: **"Do you have any questions about what I have told you today?"**

- *Answer questions as necessary.*

Ask: **"Are you interested in taking part in this study?"**

- *If person says "No", thank them for their time and say good-bye*
- *If person says "Yes", I will continue by setting up an appointment for an interview. PI will gather the following information:*
    - *Method of interview (in-person or by Microsoft Teams)*
    - *Date and time, and location (if in-person)*
    - *How they can contact myself, my supervisors, or the ethics board if they have any questions or concerns before or after the interview. If participant would like to conduct the interview online, we will arrange a date and time during this phone call. If we are unable to confirm a time during the phone call (due to the room booking process) then I will gather some dates and times that work for the participant and contact them when I have a confirmed date and time.*
- Ask: **"Do you have any barriers to participating in the study like transportation or paying for childcare during our appointment?"**
    - *If yes, PI will ask what the cost would be and offer discretionary funding to be reimbursed when the participant is given the rest of the honorarium for study participation.*
- Ask: **"How would you prefer for me to contact you going forward?"**
    - *Determine if they would like communications about the study to be by phone, text, or email. Gather this contact information from participant.*
- Ask: **"I have a list of mental health and addiction resources in Nova Scotia that I give to all participants. Can I email you this or give you a copy when we meet?"**
    - *If yes, collect email and send **Appendix L** or provide copy in person (a copy will also be attached to the consent form).*

Appendix C: List of Meeting Locations

Halifax/Clayton Park:

- Halifax Central Library (5440 Spring Garden Road)
- Halifax North Memorial Public Library (2285 Gottingen Street)
- Killam Memorial Library (6225 University Avenue)
- Chocolate Lake Community Centre (1014 Purcells Cove Road)
- George Dixon Community Centre (2501 Gottingen Street)
- Isleville Centre (3460 Isleville Street)
- Needham Community Centre (3372 Devonshire Avenue)
- St. Andrew’s Community Centre (3380 Barnstead Lane)
- Captain William Spry Community Centre (16 Sussex Street)
- Keshen Goodman Public Library (330 Lacewood Dr)

Dartmouth/Eastern Passage:

- Alderney Gate Public Library (84 Alderney Drive)
- Woodlawn Public Library (31 Eisener Boulevard)
- Cole Harbour Public Library (51 Forest Hills Parkway)
- Findlay Community Centre (26 Elliot Street)
- Horizon Recreation Centre (168 Redoubt Way, Eastern Passage)

East Preston:

- Preston Township Library (1900 Trunk 7)

North Preston:

- North Preston Community Centre (44 Simmonds Road)

Eastern Shore:

- Musquodoboit Harbour Public Library (7900 Nova Scotia Trunk 7)
- Sheet Harbour Public Library (22756 Nova Scotia Trunk 7)

Bedford/Sackville

- Bedford Public Library (15 Dartmouth Rd)
- Bedford Hammond Plains Community Centre (202 Innovation Drive)
- LeBrun Community Centre (36 Holland Avenue)
- Sackville Public Library (636 Sackville Drive)
- Sackville Sports Stadium (409 Holland Avenue)

Other HRM:

- Lakeside Community Centre (1492 St Margarets Bay Road)
- Tantallon Public Library (3646 Hammonds Plain Road)
- Gordon R. Snow Community Centre (1359 Fall River Road)

Hants/Colechester/Cumberland Counties:

- Lloyd E. Matheson Centre (15 commerce Court, Suite 100, Elmsdale)
- Truro Library (754 Price Street, Truro)
- Four Fathers Memorial Library (21 Acadia Street, Amherst)

Eastern Counties:

- Mulgrave Branch Library (390 Murray Street, Mulgrave)
- Cyril Ward Memorial Public Library (27 Pleasant Street, Guysborough)

Western Counties:

- McKay Memorial Library (17 Glasgow Street, Shelburne)
- Izaak Walton Killam Memorial Library (405 Main Street, Yarmouth)
- Isaiah W. Wilson Memorial Library (84 Warwick Street, Digby)

Annapolis Valley:

- Windsor Regional Library (195 Albert Street)
- Wolfville Memorial Library (21 Elm Avenue)
- Kentville Library (440 Main Street)
- Annapolis Royal Library (143 Ritchie Street)

Cape Breton:

- Port Hawkesbury Public Library (304 Pitt Street, Port Hawkesbury)
- Cape Breton Regional Library (50 Falmouth Street, Sydney)

Appendix D: Email Script

Dear [insert name here],

Thank you for your email. My name is Allison Prosser. I am a master's student in Dalhousie School of Nusing and my research is supervised by Dr. Ingrid Waldron and Dr. Jean Hughes. I am interested in working with you for my study. My study is called: **Black Nova Scotians in the Psychiatric System: Exploring the Experiences of Black Nova Scotians with Involuntary Psychiatric Care through an Intersectional Lens.**

I am doing this study because I want to hear the stories of Black Nova Scotians who have an involuntary psychiatric admission (have been in the hospital against their wishes). I am collecting your stories to learn from your experiences in the hospital. I hope to talk to 20-25 people about their experiences.

To be a part of this study you should:

- Be 18 years old or older
- Be able to read and understand English.
- Be Black or African Nova Scotian. You can be born here or have moved here later in life.
- And you have had at least one stay in the hospital where you were involuntary (against your wishes) or were under a Community Treatment Order (CTO) while in Nova Scotia.

You are not able to participate in the study if you are currently under involuntary treatment (e.g., currently admitted involuntarily or on a Community Treatment Order).

What would you have to do?

- Take part in a 10-minute phone call with me to make sure you meet the criteria above. You can also ask me any questions at this time. We can also do this over email if you prefer.
    - Have a 1-hour interview with me on the in-person or on Microsoft Teams. Microsoft Teams is a free software that can be installed on a computer or smart phone. You will need to have a private space where you cannot be overheard to have this conversation.
    - If we meet in person, I will give you a list of places that we could meet. These places are around the province. We will meet in a private room in a library or community centre. You will pick the place that works best for you.

    - During this interview I will ask you questions about your time in the hospital. I will ask you questions about the time before and after you were taken to the hospital. You can tell me as much or as little as you'd like. Your participation is completely voluntary.
- After we finish our conversation, I will send you a written copy of what you said. I will send you an electronic file through OneDrive. You can let me know if you want anything changed or removed that makes you uncomfortable or that you think will let people know that you were a part of this study.
    - I will respect your privacy in this study and will not include your name in the final study report. For example, I will take out any details like where you live, work, or what hospital you went to.
    - Once you look over this document, we can talk on the phone or on Teams if you have any changes that you want me to make. Reviewing this document will take 20 minutes to 1-hour.
- If you would like to receive a copy of the final study, you can let me know and I will send you a copy once it is complete.

If you are interested in being a part of this study or have any questions, please respond to this email and we can set up a time to talk on the phone.

I have also included a list of mental health resources in Nova Scotia below for your reference.

Thank you for taking the time to reach out, and I hope to hear from you soon.

Sincerely,

Allison Prosser

Mental Health and Addictions Resource List

- **Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167**
  The Mental Health Mobile Crisis Team (MHMCT) provides crisis support for children, youth and adults experiencing a mental health crisis. Service offers telephone crisis support 24 hrs a day 7 days a week anywhere in Nova Scotia and a Mobile Response from 1 pm to 1 am to most communities in Halifax Regional Municipality.

- **Kids Help Phone: 1-800-668-6868 or Text CONNECT to 686868**

Kids Help Phone is Canada's only 24/7 national **service** offering professional counselling, information, referrals and volunteer-led, text-based support for young people (up to age 25) in English and French.

- **Emergency: 911**

  Emergency services.

- **NSHA Mental Health and Addictions Intake: 1-855-922-1122**

  If you need help with a mental health or addiction concern you can call this number to be connected to NSHA Mental Health and Addiction services. Real people Monday – Friday, 8:30am to 4:30pm. Voicemail evenings, weekends, and holidays.

- **211: Call 211 or www.211.ca**

  211 is a free, confidential information and referral service that can connect you to thousands of programs and services offered by local community groups, nonprofits and government departments across Nova Scotia, 24/7.

- **Nova Scotia Health and Addictions Website: www.mha.nshealth.ca**

  The website for Nova Scotia Health Mental Health and Addictions. There are a variety of free, online resources for issues such as worry and anxiety, depression, gambling, alcohol use, and wellness.

- **Pause Mental Health Walk-in Clinic: 1-800-598-5270**

  Call 1-800-598-5270 at any time, leave your name and a call back number and the coordinator will reach out to you with an appointment time on a Tuesday or Thursday between 5pm and 8pm. Located out of the North End Community Health Centre (Gottingen Street, Halifax).

- **Veith House: 902-453-4320 or www.veithhouse.com**

  An inclusive neighbourhood hub that provides equitable and relevant services and opportunities, to foster a healthier more vibrant community. They offer counselling, advocacy, and community programming (3115 Veith St, Halifax).

- **Nova Scotia Brotherhood Initiative, to make an appointment or for general information call: 902-434-0824 or email: nsbrotherhood@cdha.nshealth.ca**

  Nova Scotia Brotherhood Initiative is a free program for Black men to access health care in the community to improve overall health and wellbeing. A team of health care professionals provide culturally-appropriate primary medical care plus health and wellness services for men of African descent across Halifax Regional Municipality.

Appendix E: Consent Form

DALHOUSIE
UNIVERSITY

Project title: Black Nova Scotians in the Psychiatric System: Exploring the Experiences of Black Nova Scotians with Involuntary Psychiatric Care through an Intersectional Lens.

Lead researcher: Allison Prosser, School of Nursing, Dalhousie University, Email: allison.prosser@dal.ca, phone: 902-233-0810.
Supervisors: Dr. Jean Hughes, School of Nursing, Dalhousie University, Email: Jean.hughes@dal.ca
Dr. Ingrid Waldron, HOPE Chair in Peace and Health, Faculty of Humanities, McMaster University; Cross-appointed Professor, School of Nursing, Dalhousie University, Email: waldroni@mcmaster.ca

Introduction

You have been invited to take part in a research study being conducted by Allison Prosser, a master's student in the School of Nursing at Dalhousie University.

The study will include 20-25 diverse Black Nova Scotians (African Nova Scotians/Canadians, Black Nova Scotians/Canadians, Caribbean Nova Scotians/Canadians) who are 18 years of age and over, who have had an involuntary hospital stay for mental health or have been under a Community Treatment Order (CTO) while in Nova Scotia.

Please note you are not able to participate in the study if you are currently under involuntary treatment (e.g., currently admitted involuntarily to the hospital or on a Community Treatment Order).

In this study you will be asked questions about your experience with involuntary psychiatric care. Your stories will help me to understand the experience of Black people who have an involuntary psychiatric care in Nova Scotian.

Your participation in this study is voluntary and choosing whether or not to take part in this research is entirely your choice. **You will be paid $50 cash for your time.** The information below tells you what you will be asked to do and about any benefit, risk, inconvenience, or discomfort that you might experience.

If you have questions about this study, please contact me. You can ask me as many questions as you like. If you have questions later, you can contact me by phone at (902)

233-0810, or by email at allison.prosser@dal.ca. If you would like to contact my supervisors, you can email Dr. Waldron at waldroni@mcmaster.ca or Dr. Jean Hughes at Jean.Hughes@dal.ca. If you have questions about the Ethics review process, you can contact the Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca.

Purpose and Outline of the Research Study

This study will focus on diverse Black people's experiences with involuntary psychiatric admissions, including how this experience was affected by:

- race,
- culture,
- gender,
- sexual orientation,
- income,
- immigrant experiences,
- disability,
- and age.

I will ask about how you think your family and community impacted the mental health care received. I will also ask about your opinions about mental health problems and asking for help for mental health problems. I will ask about your opinions about the mental health system and involuntary psychiatric care.

Who Can Take Part in the Research Study?

Black people who were born here and who have immigrated here can participate. You must be 18 years of age and over, and have had at least one involuntary admission or have been placed under a Community Treatment Order while in Nova Scotia. You should be able to read and understand English.

If you are currently under involuntary treatment (e.g., currently admitted involuntarily or on a Community Treatment Order) you are **not** eligible to take part in this study.

What You Will Be Asked to Do

The total time of this study will be 1.5 to 2 hours of your time. This will take place in three steps.

- Step 1: We will talk on the phone or over email for you to learn about the project, ensure eligibility, and provide informed consent: 10 minutes.
- Step 2: You participate in interview (online or in-person): 1 hour.
    - As a participant in this study, you are being asked to sit down for an interview in-person or the Microsoft Teams video platform. This interview will be audio recorded and will last no more than one hour. At the interview, you will be asked to talk about:
        - your experience with involuntary psychiatric care,

        - how this experience has been affected by your race, culture, gender, sexual orientation, income, immigrant experiences, and disability.
        - You will be asked about how your family and community impact your mental health care.
- Step 3: You will review transcript of interview: 20 minutes to 1 hour.
    - After the interview, you will be given a chance look at the written transcript from our interview so that you can let me know if anything should be changed or taken out or if you are happy with everything in the document. You can remove any details that you think might identify you. You can also take out details that you feel might reflect poorly on the Black community.
    - I will send you this document by email. You can make any changes or take out information you do not want to be included in the final study.

Where Will the Interview Take Place?

The interview will be scheduled on a date and a time that is convenient for you. We can meet in-person or talk on through the Microsoft Teams video platform. If you would like to use Microsoft Teams, you can install this software on a computer or smartphone, but you will need access to the internet. To protect your privacy, you will need a place to talk to me that is private and that no one can hear you or see your screen. If you choose to meet in person, you can choose where we meet from a list of community locations across Nova Scotia. We will meet in a private room in places like a library, community centre, or at Dalhousie University.

Possible Benefits, Risks and Discomforts

Possible benefits: You will be paid $50 for your time. You will be paid even if you do not complete the interview.

By telling me your stories you will help me understanding the unique experience of Black people who have had a hospital stay against their wishes (an involuntary admission). This information has not been collected in Nova Scotia, so it could be helpful in creating policies in the mental health system that reflect the actual experience of Black people who have involuntary psychiatric care.

Risks: For this study, I will ask you about sensitive topics that might make you feel upset, angry, or other emotions. Topics we may talk about are:

- What happened leading up to, during, and after involuntary psychiatric care.
- The role of your family and community during this time, as well as questions about your experience with mental illness.

If you start to become uncomfortable you can stop or pause the interview. You can tell me that you do not want to answer a certain question. It is okay to feel these emotions during our talk, but you do not have to. You do not have to finish the interview. It is important to know that I also work as a registered nurse with folks experiencing mental health problems. I can help you to relax if you need help during our conversation. I will also give everyone a list of mental health services in Nova Scotia that you can use if you need support after the interview.

There is a risk that the results of this study will lead to increased stigma of the Black community and of people with mental illness. This is why I am asking you to look over your interview transcript after our conversation. You can tell me if anything that you said might cause more stigma for these groups. I am also working with a group team of people to help guide my research. Some of the members of this group are Black and African Canadian. They will help to make sure that my final report will not harm the Black Nova Scotian community.

Conflict of Interest:
I want to let you know that I work as a registered nurse for Nova Scotia Health. I work in Community Mental Health and Addictions, and I have worked on Abbie Lane (6 and 7 Lane from 2017-2018). This study is not connected with NSH or Abbie Lane in anyway. If you receive services from people in these agencies, I will not tell them that you are participating or what you said during our interview.

In my role at Community Mental Health and Addictions I counsellor people with mental illness. Our interview is not a counselling session. I want to hear your story about involuntary psychiatric care as part of a research study to understand the experience of Black Nova Scotians who have gone through similar experiences to yours. If you are looking for counselling, please look at the list I have given you of mental health resources. Please let me know if you have any questions about the names on that list.

How your information will be protected
Privacy: I (Allison Prosser) will be the only one who will know your full name. However, three other people may listen to all or part of your interview.

- I will use a transcriber to help me transcribe your interview to paper. This person will sign a confidentiality agreement and will not share any of your information.
- My supervisors, Dr. Jean Hughes and Dr. Waldron may also hear or read part of your transcript.

I will keep the consent form with your signature and contact information separate from the actual interview transcript. The only people who will hear your interview are me, the transcriber, and my supervisors.

The audio file from your interview be destroyed after it is transcribed. I will take the identifying information out of your transcript (like your name, where you live, where you work). The transcripts will be used for this research study. They will be saved on a private online drive and destroyed after 5 years, as per the recommendation of the Dalhousie Office of Research Services. Five years will be calculated by the time that the study has been completed (approximately March 2022, to be destroyed March 2027). You should also know that quotes from your interview may be used in analysis and presentation of data, and that under no circumstances will your identity (like where you live, work, or what hospital you went to) be revealed in these quotes.

Confidentiality: Your information will be kept confidential. Your consent form with your name will be kept separately from your transcript. I (Allison Prosser) will be the only one who will know your identity. When I am discussing my research with my supervisors and when I am writing and sharing my results your name will not be shared with anyone.

Anonymity: If quotations from your interview are used in reports on the research findings, no name will be attached. In addition, information that could identify you will be removed or altered to protect your privacy. None of the results of this study will reveal your identity. Only de-identifiable information (information without your name or any identifying details, like where you live, work, or what hospital you went to) will be made available in the final study report, in presentations delivered to students and faculty at Dalhousie and to the public; in articles published in academic journals, or in papers presented at academic conferences.

Limits to confidentiality:
I will not disclose any information about your participation except as required by law. If you inform us about abuse or neglect of a child or an adult in need of protection, I am required by law to contact authorities.

If You Decide to Stop Participating

- Your participation in this study is completely voluntary and you can stop the study at any time. This includes: during the interview scheduling process;
- during the interview;
- and before the data are analyzed.

If you decide not to participate in the study or to withdraw at any time, you can also decide if you want any of the information you discussed during the interview to be removed or if you will allow me to use that information. After you review your transcript, you have two weeks to tell me if you want to withdraw from the study. After this time, it will be impossible to remove your information.
If you start the interview and decide for any reason to stop, you will still get paid the full $50.

How to Get the Results
You will be given the chance to read a copy of your interview transcript within two weeks of the interview. You then have two more weeks to let me know if you want me to remove your interview data from the study. You should know that after that time it will be impossible remove your transcript as data analysis will have started, and once this process has started it will be impossible to remove your part from the study.
If you choose to read your transcripts, you will need to give me your email to me on the signature page of this form so you can receive the transcript. You can receive a copy of the summary report by providing an email.

The findings from this study will be shared in several ways:
1) sharing the final study report with the study participants;
2) delivering public lectures to students and faculty at Dalhousie, as well as the general public;
3) sharing study findings at academic conferences; and
4) publishing in journals.

Use of my transcript in future studies

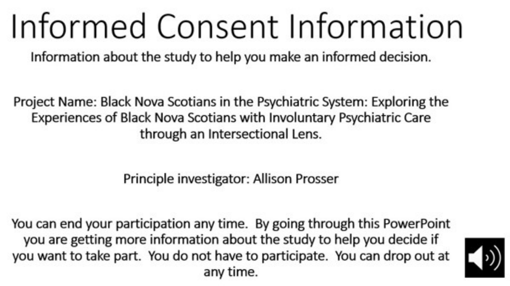
Your interview transcript and documents might be re-read and re-analyzed to help me develop future studies, which will also be focused on understanding the experience of diverse Black people who have experienced involuntary psychiatric care.

If your interview transcript and documents are used for future studies, I will ensure that only de-identifiable information will be shared for those studies (to protect your privacy). If you agree that your interview transcript can be used by me for further studies, it will be retained indefinitely (forever). I will keep backup copies of de-identified interviews in my private file storage (OneDrive), which is password protected. If you do not consent to the use of your interview transcript in future studies, it will be deleted/destroyed after the final report for this study is completed and released.

Questions

You can contact myself, or Dr. Waldron or Dr. Hughes to ask any further details about your participation in the study. And, if you have any concerns about the ethical procedures of this study, you can contact the Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca.

Appendix F: PowerPoint Consent



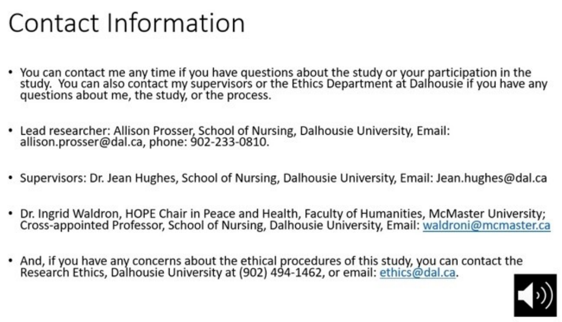
Informed Consent Information

Information about the study to help you make an informed decision.

Project Name: Black Nova Scotians in the Psychiatric System: Exploring the Experiences of Black Nova Scotians with Involuntary Psychiatric Care through an Intersectional Lens.

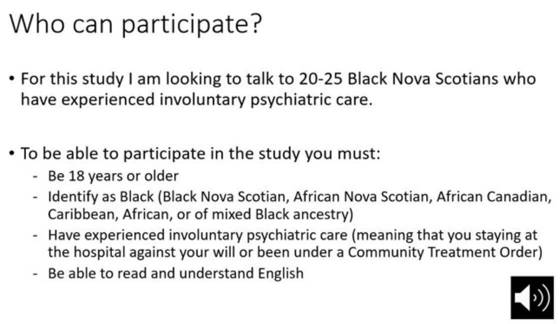
Principle investigator: Allison Prosser

You can end your participation any time. By going through this PowerPoint you are getting more information about the study to help you decide if you want to take part. You do not have to participate. You can drop out at any time.



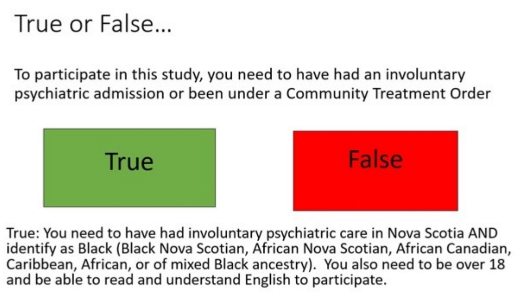
Contact Information

- You can contact me any time if you have questions about the study or your participation in the study. You can also contact my supervisors or the Ethics Department at Dalhousie if you have any questions about me, the study, or the process.
- Lead researcher: Allison Prosser, School of Nursing, Dalhousie University, Email: allison.prosser@dal.ca, phone: 902-233-0810.
- Supervisors: Dr. Jean Hughes, School of Nursing, Dalhousie University, Email: Jean.hughes@dal.ca
- Dr. Ingrid Waldron, HOPE Chair in Peace and Health, Faculty of Humanities, McMaster University; Cross-appointed Professor, School of Nursing, Dalhousie University, Email: waldroni@mcmaster.ca
- And, if you have any concerns about the ethical procedures of this study, you can contact the Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca.



Who can participate?

- For this study I am looking to talk to 20-25 Black Nova Scotians who have experienced involuntary psychiatric care.
- To be able to participate in the study you must:
  - Be 18 years or older
  - Identify as Black (Black Nova Scotian, African Nova Scotian, African Canadian, Caribbean, African, or of mixed Black ancestry)
  - Have experienced involuntary psychiatric care (meaning that you staying at the hospital against your will or been under a Community Treatment Order)
  - Be able to read and understand English



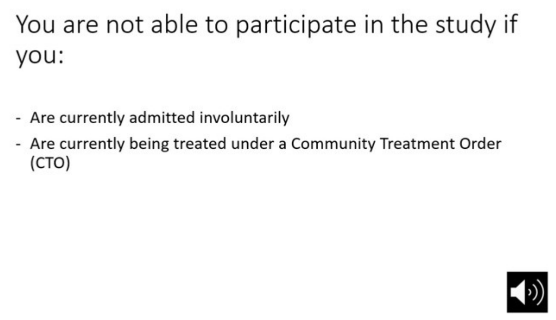
True or False…

To participate in this study, you need to have had an involuntary psychiatric admission or been under a Community Treatment Order

True

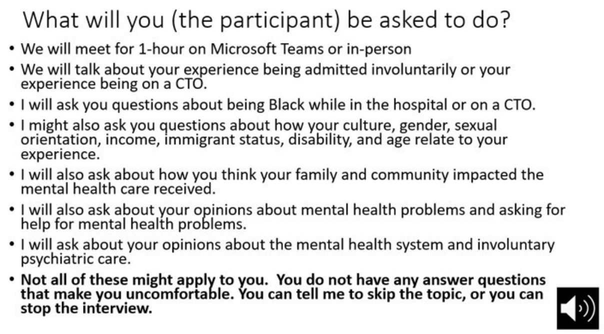
False

True: You need to have had involuntary psychiatric care in Nova Scotia AND identify as Black (Black Nova Scotian, African Nova Scotian, African Canadian, Caribbean, African, or of mixed Black ancestry). You also need to be over 18 and be able to read and understand English to participate.



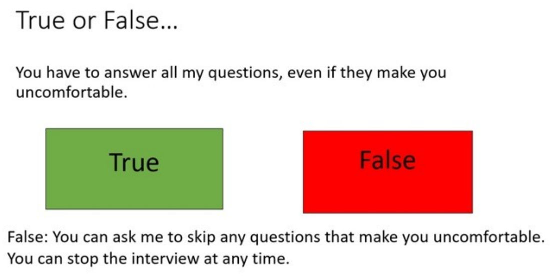
You are not able to participate in the study if you:

- Are currently admitted involuntarily
- Are currently being treated under a Community Treatment Order (CTO)



What will you (the participant) be asked to do?

- We will meet for 1-hour on Microsoft Teams or in-person
- We will talk about your experience being admitted involuntarily or your experience being on a CTO.
- I will ask you questions about being Black while in the hospital or on a CTO.
- I might also ask you questions about how your culture, gender, sexual orientation, income, immigrant status, disability, and age relate to your experience.
- I will also ask about how you think your family and community impacted the mental health care received.
- I will also ask about your opinions about mental health problems and asking for help for mental health problems.
- I will ask about your opinions about the mental health system and involuntary psychiatric care.
- **Not all of these might apply to you. You do not have any answer questions that make you uncomfortable. You can tell me to skip the topic, or you can stop the interview.**



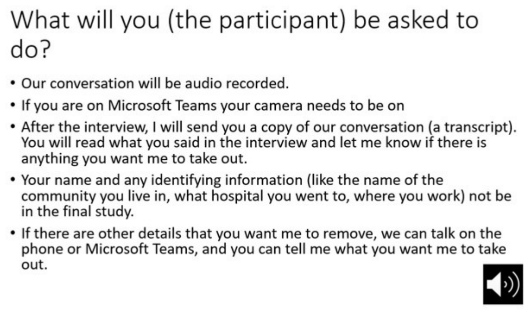
True or False…

You have to answer all my questions, even if they make you uncomfortable.

True

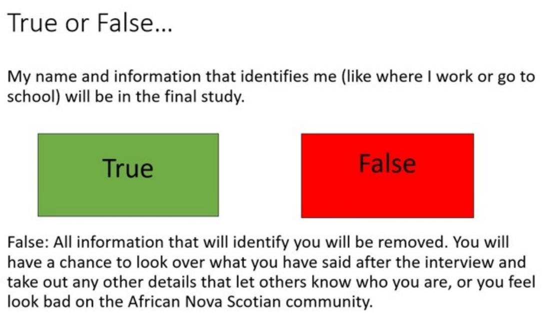
False

False: You can ask me to skip any questions that make you uncomfortable. You can stop the interview at any time.



What will you (the participant) be asked to do?

- Our conversation will be audio recorded.
- If you are on Microsoft Teams your camera needs to be on
- After the interview, I will send you a copy of our conversation (a transcript). You will read what you said in the interview and let me know if there is anything you want me to take out.
- Your name and any identifying information (like the name of the community you live in, what hospital you went to, where you work) not be in the final study.
- If there are other details that you want me to remove, we can talk on the phone or Microsoft Teams, and you can tell me what you want me to take out.



True or False…

My name and information that identifies me (like where I work or go to school) will be in the final study.

True

False

False: All information that will identify you will be removed. You will have a chance to look over what you have said after the interview and take out any other details that let others know who you are, or you feel look bad on the African Nova Scotian community.

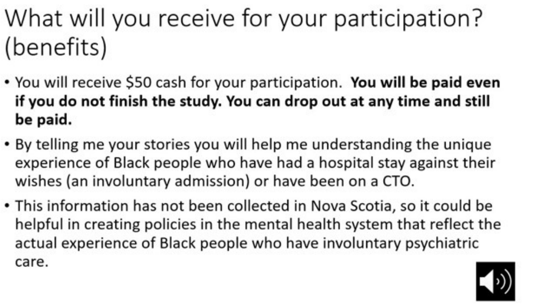
True or False…

If we meet online, I need my camera on. All our conversation will be audio recorded so it can be analyzed for research.

True

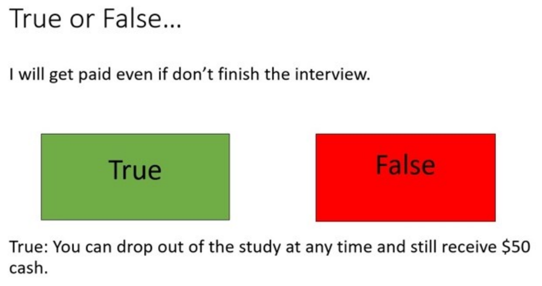
False

True: I need to see your face during our conversation, so your camera needs to be turned on. I will be recording the interview, so I use it for research.



What will you receive for your participation? (benefits)

- You will receive $50 cash for your participation. **You will be paid even if you do not finish the study. You can drop out at any time and still be paid.**
- By telling me your stories you will help me understanding the unique experience of Black people who have had a hospital stay against their wishes (an involuntary admission) or have been on a CTO.
- This information has not been collected in Nova Scotia, so it could be helpful in creating policies in the mental health system that reflect the actual experience of Black people who have involuntary psychiatric care.



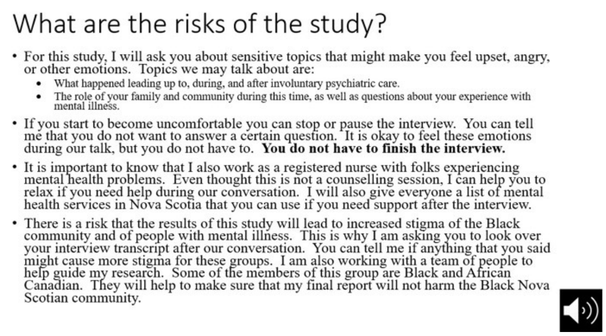
True or False…

I will get paid even if don’t finish the interview.

True

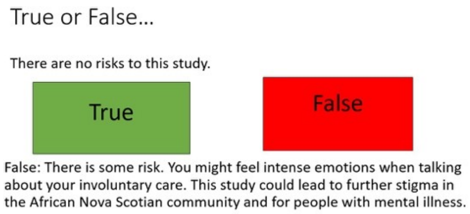
False

True: You can drop out of the study at any time and still receive $50 cash.



What are the risks of the study?

- For this study, I will ask you about sensitive topics that might make you feel upset, angry, or other emotions. Topics we may talk about are:
  - What happened leading up to, during, and after involuntary psychiatric care.
  - The role of your family and community during this time, as well as questions about your experience with mental illness.
- If you start to become uncomfortable you can stop or pause the interview. You can tell me that you do not want to answer a certain question. It is okay to feel these emotions during our talk, but you do not have to. **You do not have to finish the interview.**
- It is important to know that I also work as a registered nurse with folks experiencing mental health problems. Even thought this is not a counselling session, I can help you to relax if you need help during our conversation. I will also give everyone a list of mental health services in Nova Scotia that you can use if you need support after the interview.
- There is a risk that the results of this study will lead to increased stigma of the Black community and of people with mental illness. This is why I am asking you to look over your interview transcript after our conversation. You can tell me if anything that you said might cause more stigma for these groups. I am also working with a team of people to help guide my research. Some of the members of this group are Black and African Canadian. They will help to make sure that my final report will not harm the Black Nova Scotian community.



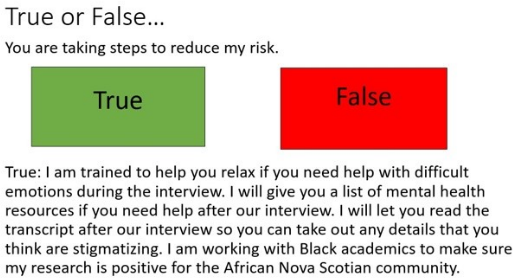
True or False…

There are no risks to this study.

True

False

False: There is some risk. You might feel intense emotions when talking about your involuntary care. This study could lead to further stigma in the African Nova Scotian community and for people with mental illness.



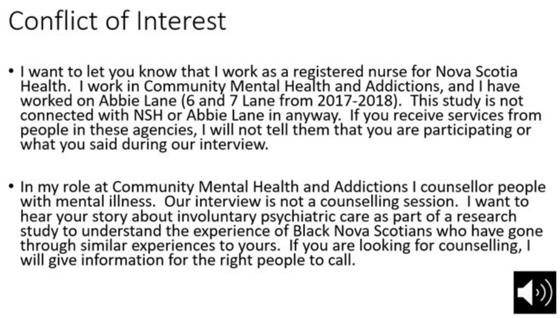
True or False…

You are taking steps to reduce my risk.

True

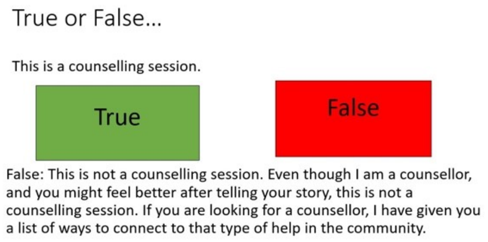
False

True: I am trained to help you relax if you need help with difficult emotions during the interview. I will give you a list of mental health resources if you need help after our interview. I will let you read the transcript after our interview so you can take out any details that you think are stigmatizing. I am working with Black academics to make sure my research is positive for the African Nova Scotian community.



Conflict of Interest

- I want to let you know that I work as a registered nurse for Nova Scotia Health. I work in Community Mental Health and Addictions, and I have worked on Abbie Lane (6 and 7 Lane from 2017-2018). This study is not connected with NSH or Abbie Lane in anyway. If you receive services from people in these agencies, I will not tell them that you are participating or what you said during our interview.
- In my role at Community Mental Health and Addictions I counsellor people with mental illness. Our interview is not a counselling session. I want to hear your story about involuntary psychiatric care as part of a research study to understand the experience of Black Nova Scotians who have gone through similar experiences to yours. If you are looking for counselling, I will give information for the right people to call.



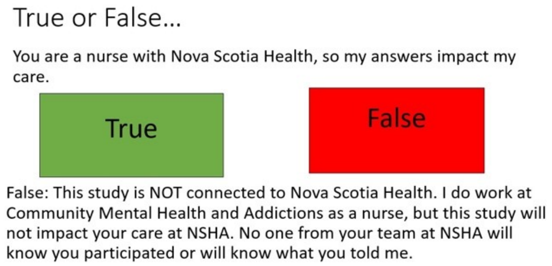
True or False…

This is a counselling session.

True

False

False: This is not a counselling session. Even though I am a counsellor, and you might feel better after telling your story, this is not a counselling session. If you are looking for a counsellor, I have given you a list of ways to connect to that type of help in the community.



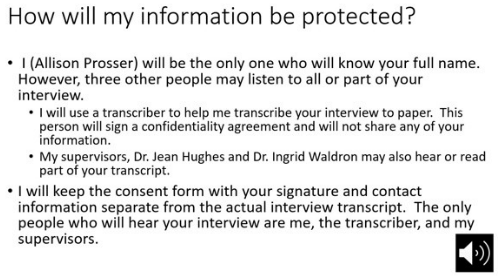
True or False…

You are a nurse with Nova Scotia Health, so my answers impact my care.

True

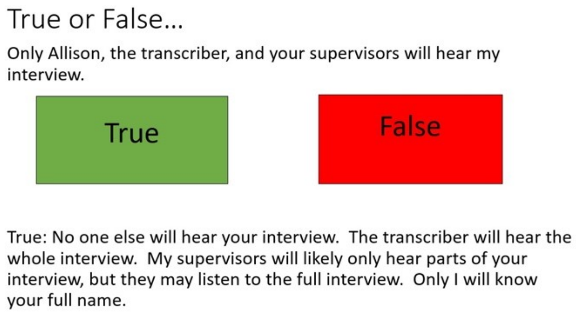
False

False: This study is NOT connected to Nova Scotia Health. I do work at Community Mental Health and Addictions as a nurse, but this study will not impact your care at NSHA. No one from your team at NSHA will know you participated or will know what you told me.



How will my information be protected?

- I (Allison Prosser) will be the only one who will know your full name. However, three other people may listen to all or part of your interview.
  - I will use a transcriber to help me transcribe your interview to paper. This person will sign a confidentiality agreement and will not share any of your information.
  - My supervisors, Dr. Jean Hughes and Dr. Ingrid Waldron may also hear or read part of your transcript.
- I will keep the consent form with your signature and contact information separate from the actual interview transcript. The only people who will hear your interview are me, the transcriber, and my supervisors.



True or False…

Only Allison, the transcriber, and your supervisors will hear my interview.

True

False

True: No one else will hear your interview. The transcriber will hear the whole interview. My supervisors will likely only hear parts of your interview, but they may listen to the full interview. Only I will know your full name.

How will my information be protected?

- The audio file from your interview be destroyed after it is transcribed.
- I will take the identifying information out of your transcript (like your name, where you live, where you work).
- The transcripts will be used for this research study.
- They will be saved on a private online drive and destroyed after 5 years
- You should also know that quotes from your interview may be used in analysis and presentation of data, and that under no circumstances will your identity (like where you live, work, or what hospital you went to) be revealed in these quotes.

True or False…

The audio file of my interview will be kept forever.

True   False

False: I will destroy the audio file as soon as it has been typed out. Once it is typed, I will take out any information that might let others know who you are.

What are the limits to confidentiality?

- I will not disclose any information about your participation except as required by law.
- If you inform me about abuse or neglect of a child or an adult in need of protection, I am required by law to contact authorities.

True or False…

You have to tell the authorities is a child or vulnerable person is being abused or neglected.

True   False

True: If this happens, I have to break our confidentiality and inform the authorities. If this happens, I will tell you that I am making the call, but I am required by law to follow up if I learn of this information.

What if I stop participating (drop out of the study)?

- Your participation in this study is **completely voluntary** and you can stop the study at any time.
- This includes:
  - during the interview scheduling process;
  - during the interview;
  - and before the data are analyzed.
- If you decide not to participate in the study or to withdraw at any time, you can also decide if you want any of the information you discussed during the interview to be removed or if you will allow me to use that information.
- After you review your transcript, you have two weeks to tell me if you want to withdraw from the study. After this time, it will be impossible to remove your information.
- If you start the interview and decide for any reason to stop, **you will still get paid the full $50.**

True or False…

I can stop any time and still be paid.

True

False

True: You can stop any time and you do not have to tell me the reason.
I will still pay you even if you do not finish the interview.

True or False…

I can tell you to take out my interview after I have submitted it.

True

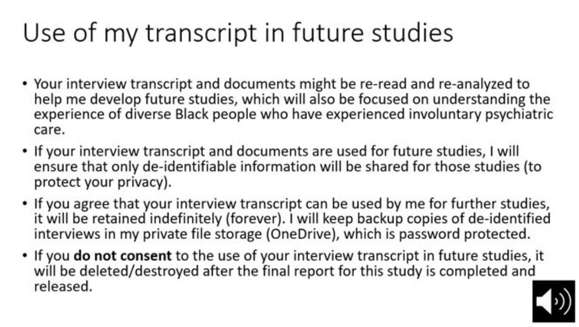
False

False: You need to tell me that you want to take your interview out of the study within two weeks us discussing your feedback.

Can I see the results of the study?

- You will be given the chance to read a copy of your interview transcript within two weeks of the interview.
- You then have two more weeks to let me know if you want me to remove your interview data from the study.
- You should know that after that time it will be impossible remove your transcript as data analysis will have started, and once this process has started it will be impossible to remove your part from the study.
- If you choose to read your transcripts, you will need to give me your email to me on the signature page of this form so you can receive the transcript. You can receive a copy of the summary report by providing an email or postal address.

- The findings from this study will be shared in several ways:
  - sharing the final study report with the study participants;
  - delivering public lectures to students and faculty at Dalhousie, as well as the general public;
  - sharing study findings at academic conferences; and
  - publishing in journals.

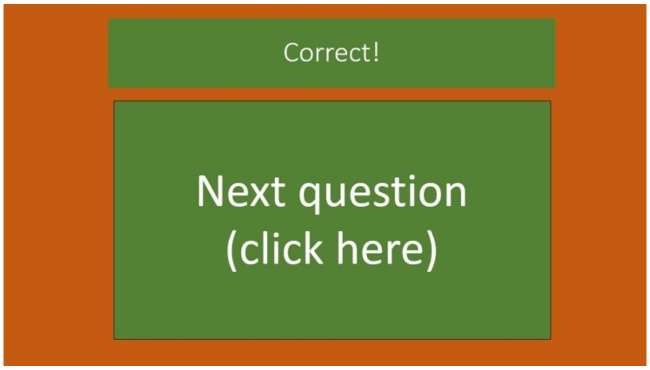


Use of my transcript in future studies

- Your interview transcript and documents might be re-read and re-analyzed to help me develop future studies, which will also be focused on understanding the experience of diverse Black people who have experienced involuntary psychiatric care.
- If your interview transcript and documents are used for future studies, I will ensure that only de-identifiable information will be shared for those studies (to protect your privacy).
- If you agree that your interview transcript can be used by me for further studies, it will be retained indefinitely (forever). I will keep backup copies of de-identified interviews in my private file storage (OneDrive), which is password protected.
- If you **do not consent** to the use of your interview transcript in future studies, it will be deleted/destroyed after the final report for this study is completed and released.

Incorrect

Try Again
(click here)



Correct!

Next question
(click here)

Appendix G: Additional Consent Conversation Guide

Question	**Key Words or Phrases**	**Notes**
Understanding: The participant demonstrates understanding of the study and what participation requires of them.		
What is the purpose of this research study?	- To advance scientific knowledge. - To learn about the experience of Black Nova Scotians who have experienced involuntary psychiatric care. <u>Clarification needed:</u> Unsure of or provided incorrect answer of purpose, especially that the study is part of their treatment.	
What do I have to do in this study?	- Have a 1-hour interview with researcher. - I can review my transcript after the interview if I want. - If I am meeting on Microsoft Teams, I have to have my camera on. - My interview will be audio recorded. <u>Clarification needed:</u> Unsure of or provided incorrect answer of what is required of them for this study.	
What kinds of questions will the researcher ask me?	The primary researcher will ask me about: - My experiences before, during, and after involuntary admission. - How this experience has been affected by your race, culture, gender, sexual orientation, income, immigrant experiences, and disability. - How your family and community impact your mental health care. <u>Clarification needed:</u> Unsure of or provided incorrect answer of the kinds of questions the primary researcher will ask.	
Do I have to answer a question if I don't want to?	- No, the participant can skip any question that they don't want to answer for any reason. <u>Clarification needed:</u> Unsure or believe they must answer all questions.	

Who will know my identity after participating in this study?	- Only the primary researcher will know your full identity. - The person typing up your interview (transcriber) will know your first name. She may also hear identifying details if you share them in the interview (if you mention your community or where you work, etc.) but she has signed a confidentiality agreement. - All identifying information (name, community name, where you work, hospital you went to) will be taken out of the final study. - I might ask my supervisors, Dr. Hughes, and Dr. Waldron, for advice of certain parts of your transcript, but they will not know your full identity. They may listen to parts of your transcript which might have identifying information on them, but I will not share your last name with them. - I am required by law to report if I learn that a child or adult in need of protection is experiencing abuse or neglect. If I learn this information while we are talking, I have to make a report to child/adult protection. - If I feel like you are at imminent risk to yourself or others I will work with you to manage this risk. I will ask you if there is a person we can contact (like a parent or spouse) who can help you. If not, I will ask you if we can call MHMCT together. If you do not want to do this, and you have shared information that makes me believe that you are at imminent risk to yourself or others I am obligated to contact MHMCT or the police. <u>Clarification needed:</u> Unsure of or provided incorrect answer regarding their identifying information.	

What are the potential risks of this study?	- Potential to experience uncomfortable emotions when talking about sensitive topics. - Increased stigma of the Black community and of people with mental illness. Clarification needed: Unsure of or provided incorrect answer of the potential risks.	
What are the potential benefits of this study?	- Financial compensation ($50), - helping the primary researcher learn about the unique experience of Black Nova Scotians who have experienced involuntary psychiatric care, - this knowledge contributes to wider scholarly knowledge on this topic. Clarification needed: Unsure of or provided incorrect answer of the benefits, especially that this will lead to change in the mental health system (potential benefit, but not guaranteed).	
What if you want to stop participating in this study?	- Participant can stop without penalty. - Participant will still get paid for their time if I don't complete the study ($50 plus any agreed discretionary funding). - Participant can tell the primary researcher at any time that I want to stop the interview with no consequence to them. - After you have reviewed the transcript, you have two weeks to back out. After that time, you cannot remove your information (as I will have started the data analysis process). Clarification needed: Unsure of or provided incorrect answer of how to end the study	
Appreciation: The subjects' abilities to evaluate how they will be affected by participation in this study.		
Why were you asked to participate in this study?	- Because I am a Black Nova Scotian who has experienced involuntary psychiatric care. - To help the primary researcher generate new knowledge.	

	Clarification needed: Unsure of or provided incorrect answer, especially if participant states that this interview is related to their own care or is part of their treatment.	
Do you have the option to refuse to participate?	Must answer yes. Clarification needed: state no or ambivalence.	
Reasoning: Participants' ability to compare different possibilities, draw conclusions about how participating in this study will impact the participants' daily life.		
What are the pros and cons of participating in this study	Pros: financial compensation, helping to generate new knowledge, potential to have story validated/catharses Cons: time, potential to experience uncomfortable emotions, potential for stigma to Black Nova Scotian community and towards people with mental illness. Clarification needed: Unsure of or provided incorrect answer.	
What are the pros and cons of not participating in this study?	Pros: avoid talking about potentially difficult subjects. Cons: potentially missing out on financial compensation. Clarification needed: Unsure of pros and cons of not participating.	
Why did you choose to reply to the study poster?	Wanted to talk about my story; financial compensation; interested in helping generate new knowledge. Clarification needed: Unsure or incorrect information, especially if they say they are looking for treatment	
Choice: The person expresses a choice to participate in the study.		
Are you choosing to participate in this study?	Must state "yes". Clarification needed: state no or ambivalence. If they state no, then end their participation. If they voice ambivalence, ask them what information needs clarification, ask them if they want to reschedule so they have time to think about their participation.	

Appendix H: Signature Page

Project Title: Black Nova Scotians in the Psychiatric System: Exploring the Experiences of Black Nova Scotians with Involuntary Psychiatric Care through an Intersectional Lens.

Lead Researcher: Allison Prosser, School of Nursing, Dalhousie University
Supervisors: Dr. Jean Hughes, School of Nursing, Dalhousie University and Dr. Ingrid Waldron, Professor & HOPE Chair in Peace and Health, McMaster University

Understanding the consent process
I have listened to the explanation of the study. I have been able to discuss my questions. I have gotten answers to all my questions.
Yes ____ No______

I understand that that I have been asked to take part in one 60-minute interview to be conducted in-person or by Microsoft Teams.
Yes ____ No______

I understand that the interview will occur in-person or the Microsoft Teams video platform and that one else will overhear the conversation.
Yes ____ No______

Consent to participate in the study
I understand that the interview will be audio-recorded. I understand that this is required for me to participate
Yes ____ No______

NOT REQUIRED FOR PARTICIPATION IN THIS STUDY: Allison Prosser can use my transcripts in future studies conducted by her without identifying me.
Yes ____ No______

______________________________ ____________________________ ____________

Name Verbal Signature (If on Microsoft Teams)
Date

The use of quotations from my interview
I agree that excerpts may be directly quoted without my name may be used.

Yes ____ No______

Re Contacting me after the interview is completed

I would like to receive a copy of my interview transcript to review. I will let Allison Prosser know if I want to remove any or all of my interview data from the study.
Yes ____ No______

Email where transcript will be sent: ________________________

____________________________ ___________
Verbal Signature Date

I would like to receive a copy of the final report by email:

Yes ____ No______

Appendix I: Interview Guide

Black Nova Scotians in the Psychiatric System: Exploring the Experiences of Black Nova Scotians with Involuntary Psychiatric Care through an Intersectional Lens.

This study will focus on diverse Black people's experiences with involuntary psychiatric admissions, including how this experience was affected by their race, culture, gender, sexual orientation, income, immigrant experiences, disability, and age. It will look at how family and community factors impact the mental health care received. It will also look at Black people's opinions about mental health problems and seeking help for mental health problems and how these opinions might be influenced by involuntary psychiatric care.

I am particularly interested in understanding your perspectives on these issues because the information you will provide because there is no research on this topic within the Nova Scotian context. Studies like these can help inform policies that reflect the actual experience of those within the mental health system.

Please note that you do not have to answer any questions that make your uncomfortable. You can stop at any time.

General Mental Illness

1. Do you have a psychiatric diagnosis (mental illness/mental health problem)?
    a. If yes, what is your diagnosis?
    b. Describe what happens when you become unwell with your mental illness.
2. Have you been admitted to a psychiatric unit involuntarily?
    a. If yes, please tell me how many times and the general dates of these admissions?

Help Seeking

1. Who does your current mental health team consist of? (e.g., psychiatrist, nurse, social worker, peer support, GP, etc.)
2. Who do you go to for help with your mental health?
3. Currently, how do you decide when to ask for help with your mental health?
4. In the past, how did you decide when to ask for help with your mental health?
5. Did being admitted involuntarily change **how** you ask for help with your MH?
6. Did being admitted involuntarily change **when** you ask for help with your MH?

Factors Related to Involuntary Psychiatric Admission

1. Tell me about the time/the first time (if have had more than one admission) you were admitted involuntarily.
    a. How did you feel during the process?
    b. Who brought you to the hospital?
    c. How did you feel during your admission?
    d. How long were you there?
    e. How do you feel looking back on your admission?
2. When you have had to go to the hospital against your will, how was your **family** involved?
3. When you have had to go to the hospital against your will, how were your **friends** involved?
4. When you have had to go to the hospital against your will, how was your **community** involved?
5. When you have had to go to the hospital against your will, how was **the health care system** (e.g. emergency room, Mental Health Mobile Crisis, Paramedics) involved?
6. When you have had to go to the hospital against your will, how was your **community mental health team**
7. When you have had to go to the hospital against your will, how was your **family doctor** involved?
8. Looking back on your admission(s) were there any factors that you feel lead to you being admitted involuntarily instead of voluntarily?

Intersecting Identities

1. What role did race play in being admitted involuntarily to hospital?
    a. How did race shape your hospital admission(s)?
    b. How does race shape your mental health (MH) care after discharge?
2. (Only ask if migrant) What role did being [an immigrant/refugee] play in being admitted involuntarily to hospital?
    a. How did being [an immigrant/refugee] shape your hospital admission(s)?
    b. How does being [an immigrant/refugee] shape your MH care after discharge?
3. What is your gender?
4. What role did being a [stated gender] play in being admitted involuntarily to hospital?
    a. How did [stated gender] shape your hospital admission(s)?
    b. How does [stated gender] shape your MH care after discharge?
5. What is your sexual orientation?
6. What role did being [stated sexual orientation] play in being admitted involuntarily to hospital?
    a. How did [stated sexual orientation] shape your hospital admission(s)?
    b. How does [stated sexual orientation] shape your MH care after discharge?

7. What role did age play in being admitted involuntarily to hospital?
    a. How did age shape your hospital admission(s)?
    b. How does age shape your MH care after discharge?
8. Do you identity as having a disability other than mental illness? (If no, continue to next question.) If yes:
    a. What role did having a disability play in being admitted involuntarily to hospital?
    b. How did having a disability shape your hospital admission(s)?
    c. How does having a disability shape your MH care after discharge?
9. How would you identify your socioeconomic status and social class? (prompts: material deprivation, residential instability, education, employment).
    a. What role did you [stated SES] play in being admitted involuntarily to hospital?
    b. How did being [stated SES] shape your hospital admission(s)?
    c. How does being [stated SES] shape your MH care after discharge?

- Is there anything else you would like to add about your experience receiving involuntary psychiatric care?
- What would you change or keep the same about your experience?

Appendix J: Transcriber Confidentiality Agreement

THIS AGREEMENT (the "Agreement") is entered into on this date _______ by and between ____________________ (the "Discloser" or the" Disclosing Party"), and xxx Transcription Services Inc. (the "Recipient" or the "Receiving Party").

The Receiving Party desires to provide transcription services to the Disclosing Party. During the provision of services the Disclosing Party may share certain information with the Receiving Party. Therefore, in consideration of the mutual promises and covenants contained in this Agreement the parties agree as follows:

1. Definition of Confidential Information.

(a) For purposes of this Agreement, "Confidential Information" means any data or information that is proprietary to the Disclosing Party and not generally known to the public, whether in tangible or intangible form, whenever and however disclosed, including, but not limited to: (i) information contained in **audio recordings**, (ii) **transcriptions of audio recordings**; and (iii) any other information that should reasonably be recognized as confidential information of the Disclosing Party.

(b) Notwithstanding anything in the foregoing to the contrary, Confidential Information shall not include information which: (i) was known by the Receiving Party prior to receiving the
Confidential Information from the Disclosing Party; (ii) becomes rightfully known to the Receiving Party from a third-party source not known (after diligent inquiry) by the Receiving Party to be under an obligation to Disclosing Party to maintain confidentiality; (iii) is or becomes publicly available through no fault of or failure to act by the Receiving Party in breach of this Agreement; (iv) is required to be disclosed in a judicial or administrative proceeding, or is otherwise requested or required to be disclosed by law or regulation.

2. Disclosure of Confidential Information.

In accordance with seeking transcription services the Disclosing Party may disclose Confidential Information to the Receiving Party. The Receiving Party will:

(a) limit disclosure of any Confidential Information to its officers, employees, or agents (collectively "Representatives") who have a need to know such Confidential Information in order to provide the transcription services to which this Agreement relates, and only for that purpose;

(b) advise its Representatives of the very private and very confidential nature of the Confidential Information and of the obligations set forth in this Agreement and require their Representatives to sign similar legally binding Confidentiality Agreements with the Receiving Party;

(c) shall keep all Confidential Information strictly confidential by using a high degree of care and security; and
(d) not disclose any Confidential Information received by it to any third parties (except as otherwise provided for herein).

3. Use of Confidential Information.

The Receiving Party agrees to use the Confidential Information solely in connection with the provision of transcription services and not for any purpose other than as authorized by this Agreement without the prior written consent of an authorized representative of the Disclosing Party. No other right or license, whether expressed or implied, in the Confidential Information is granted to the Receiving Party hereunder. Title to the Confidential Information will remain solely in the Disclosing Party. All use of Confidential Information by the Receiving Party shall be for the benefit of the Disclosing Party and any modifications and improvements thereof by the Receiving Party shall be the sole property of the Disclosing Party.

4. Return of Confidential Information.

Receiving Party shall return, delete or destroy all recordings embodying the Confidential Information provided including all transcripts and audio recordings, upon the earlier of (i) the completion or termination of the project between the parties being contemplated hereunder; (ii) the termination of this Agreement; or (iii) at such time as the Disclosing Party may so request.

5. Miscellaneous.

(a) This Agreement constitutes the entire understanding between the parties and supersedes any and all prior understandings and agreements, whether oral or written, between the parties, with respect to the subject matter hereof. This Agreement can only be modified by a written amendment signed by the party against whom enforcement of such modification is sought.
(b) The validity, construction and performance of this Agreement shall be governed and construed in accordance with the laws of Nova Scotia (Canada) applicable to contracts made and to be wholly performed within such state, without giving effect to any conflict of laws provisions thereof. The courts located in Nova Scotia (Canada) shall have sole and exclusive jurisdiction over any disputes arising under the terms of this Agreement.
(c) Dispute Resolution (Negotiation/Mediation/Arbitration). In the event of any controversy or claim arising out of or relating to this agreement, or the breach thereof, the parties hereto shall enter into negotiation with each other and, recognizing their mutual interests, attempt to reach a solution satisfactory to both parties. If they do not reach settlement within a period of 7 days, then either party may, by notice to the other party and an online based recognised mediator, demand mediation under the Mediation Rules of the International Centre for Dispute Resolution. If settlement is not reached within 7 days after service of a written demand for mediation, any unresolved controversy or claim arising out of or relating to this contract shall be settled by arbitration administered by the ADR Institute of Canada in accordance with its Arbitration Rules. The number of

arbitrators shall be one, the place of arbitration shall be Nova Scotia (Canada). The language(s) of the arbitration shall be English.

(d) Paragraph headings used in this Agreement are for reference only and shall not be used or relied upon in the interpretation of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

Receiving Party By (Signature):
Printed Name:
Title:
Date:

Disclosing Party By (Signature):
Printed Name:
Title:
Date:

Appendix K: Coding Guide

The following table is a reference tool to help guide coding of participant transcripts. Refer to the definition and keywords to determine under which code a transcript excerpt should be categorized.

Code	**Definition**	**Keywords in Transcripts**
Trust	"To have faith or confidence in a person, quality, or thing; to rely on" (Oxford English Dictionary).	Trust, confidence, reliance/rely on, faith, believe, participant let someone else do for them
Help-seeking	"Searching for or requesting help from others via formal or informal mechanisms, such as through mental health services" (American Psychological Association, 2023).	Asked another for help or assistance, looked to others for problem solving or advice, shared symptoms or experiences with another
Stigma	Labelling human differences and linking these labels to undesirable characteristics to create stereotypes, as well as using labels and stereotypes to separate "us" from "them", which result in status loss in social hierarchies and individual and/or structural discrimination (Link and Phlen, 2001).	Shame, embarrassment, avoiding talking about mental health concerns
Role of family	Defined by the participant and may include parents and/or step-parents, (step or half) siblings, partners, and/or (step) children. Families, in this case may include (step) grandparents, (step) aunts/uncles, (step) nieces/nephews. Families may also include "chosen family" who are not genetically related to the participant but act as of one of the roles above.	Family presence, lack of family presence, roles of family members, influence of family members, benefit of family members, challenges of family dynamics
Role of community	Defined by the participant and may include friends, neighbours, community leaders, religious leaders, teachers, coaches, or informal supports (e.g., peer support persons, sponsors).	Community presence, lack of community presence, roles of community, influence of community, benefit of community, challenges of community

Role of health system	Formal services administered by a health care provider. This category includes doctors (e.g., family physicians, psychiatrists), nurses, social workers). It also includes the physical structures of the system (e.g., hospital units, emergency rooms, community clinics), and the broader "system" (e.g., laws and policies enacted by providers in the health system). Health system also includes agents of the system that enact the policies and laws of the system (e.g., police officers, Child Protective Services, lawyers and judges).	Presence (or lack thereof) of various health professionals, role of health care system, role of other agencies related to health care system (e.g., CPS, police), interactions between participant and health care system
Race	"A socially defined concept sometimes used to designate a portion, or "subdivision," of the human population with common physical characteristics, ancestry, or language. The term is also loosely applied to geographic, cultural, religious, or national groups" (American Psychological Association, 2023).	Black, African Nova Scotian, African Canadian, mixed race, heritage, culture How does identified race interact with various aspects of involuntary psychiatric care?
Gender identity	"Gender identity is each person's internal and individual experience of gender. It is a person's sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex" (Ontario Human Rights Commission, n.d.).	Gender, sex How does identified gender interact with various aspects of involuntary psychiatric care?
Sexual orientation	"A person's physical, romantic and/or emotional attraction to, and/or intimate relations with, individuals of a different gender, the same gender, no gender, or more than one gender. A person's understanding of their sexual orientation may change" (Government of Canada, 2020).	Husband, wife, partner, spouse, boyfriend, girlfriend How does your sexual orientation and relationship status interact with various aspects of involuntary psychiatric care?

Age	“The length of time (sometimes given as a specified number of years) that a living thing, as a person, animal, plant, etc., has lived” (Oxford English Dictionary).	How does age interact with various aspects of involuntary psychiatric care?
Disability	“a lasting physical or mental impairment that significantly interferes with an individual’s ability to function in one or more central life activities, such as self-care, ambulation, communication, social interaction, sexual expression, or employment” (American Psychological Association, 2023).	How does your disability, including mental illness, interact with various aspects of involuntary psychiatric care?
Socioeconomic status	“the position of an individual or group on the socioeconomic scale, which is determined by a combination of social and economic factors such as income, amount and kind of education, type and prestige of occupation, place of residence, and—in some societies or parts of society—ethnic origin or religious background” (American Psychological Association, 2023).	How does your class and SES interact with various aspects of involuntary psychiatric care?
Leading to involuntary psychiatric care (IPC)	Factors leading to, feelings about, and comments about coming into involuntary psychiatric care.	Interactions with health care agents leading to IPC, events on the timeline leading to IPC, feelings and thoughts during this time, interactions with other sub-themes (above) during this time
During involuntary psychiatric care	Situations encountered, feelings about, and comments about being held under involuntary psychiatric care.	Interactions with health care agents during IPC, events on the timeline during IPC, feelings and thoughts during this time, interactions with other sub-themes (above) during this time
After involuntary psychiatric care	Situations encountered, feelings about, and comments about the	Interactions with health care agents after IPC, events on the timeline after

	experience after experiencing involuntary psychiatric care.	IPC, feelings and thoughts during this time, interactions with other sub-themes (above) during this time
Symptoms	Changes in thinking, feeling, behaviour, and perceptions of reality related to a psychiatric illness that causes changes in day-to-day function.	Narrative related to thoughts, feelings, behaviours, and perceptions that are different than a person's baseline experience. Experiences that cause disruption in day-to-day function.
Treatment	Medications or actions provided to participant as a remedy for symptoms. May be provided by health system, self, or other not related to health system (e.g., self, family, clergy, community).	Medications, procedures, coping methods, spirituality, remedies to relieve symptoms
Diagnosis	Labels from the Diagnostic and Statistics Manual (DSM) given by an authorized diagnostician (i.e., physician, psychiatrist, nurse practitioner) to attempt to categorize symptoms.	Diagnostic names

Appendix L: Mental Health Resources

- **Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167**
  The Mental Health Mobile Crisis Team (MHMCT) provides crisis support for children, youth and adults experiencing a mental health crisis. Service offers telephone crisis support 24 hrs a day 7 days a week anywhere in Nova Scotia and a Mobile Response from 1 pm to 1 am to most communities in Halifax Regional Municipality.

- **Kids Help Phone: 1-800-668-6868 or Text CONNECT to 686868**
  Kids Help Phone is Canada's only 24/7 national **service** offering professional counselling, information, referrals and volunteer-led, text-based support for young people (up to age 25) in English and French.

- **Emergency: 911**
  Emergency services.

- **NSHA Mental Health and Addictions Intake: 1-855-922-1122**
  If you need help with a mental health or addiction concern you can call this number to be connected to NSHA Mental Health and Addiction services. Real people Monday – Friday, 8:30am to 4:30pm. Voicemail evenings, weekends, and holidays.

- **211: Call 211 or www.211.ca**
  211 is a free, confidential information and referral service that can connect you to thousands of programs and services offered by local community groups, nonprofits and government departments across Nova Scotia, 24/7.

- **Nova Scotia Health and Addictions Website: www.mha.nshealth.ca**
  The website for Nova Scotia Health Mental Health and Addictions. There are a variety of free, online resources for issues such as worry and anxiety, depression, gambling, alcohol use, and wellness.

- **Pause Mental Health Walk-in Clinic: 1-800-598-5270**
  Call 1-800-598-5270 at any time, leave your name and a call back number and the coordinator will reach out to you with an appointment time on a Tuesday or Thursday between 5pm and 8pm. Located out of the North End Community Health Centre (Gottingen Street, Halifax).

- **Veith House: 902-453-4320 or www.veithhouse.com**

An inclusive neighbourhood hub that provides equitable and relevant services and opportunities, to foster a healthier more vibrant community. They offer counselling, advocacy, and community programming (3115 Veith St, Halifax).

- **Nova Scotia Brotherhood Initiative,** to make an appointment or for general information call: 902-434-0824 or email: nsbrotherhood@cdha.nshealth.ca

Nova Scotia Brotherhood Initiative is a free program for Black men to access health care in the community to improve overall health and wellbeing. A team of health care professionals provide culturally-appropriate primary medical care plus health and wellness services for men of African descent across Halifax Regional Municipality.