DEVELOPING A NEW SERVICE MODEL
for Canadians of African Descent

Developing a New Service Model for Canadians of African Decent

Enslavement, Colonization, Racism, Identity and Mental Health

Phase I Report
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DISCLAIMER

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Executive Summary

This project, an inquiry into the specific nature of African-Canadian distress in the context of "Canadian multiculturalism," was initiated in 2002, after those most closely involved in the provision of Canadian correctional and health services observed two correlatives:

a) The over-representation of African-Canadians in the non-voluntary services (detention centres, medico-legal units in psychiatric hospitals, youth centres, etc.)
b) Their under-representation in the voluntary services (outpatient psychiatric clinics, addiction services, etc.)

These findings prompted the telling questions:

a) Could the marginalized position of African-Canadians in Canadian society be exacerbated and perpetuated by the deficiencies in the preventive and curative services available to them?
b) Could these same deficiencies—which incidentally have been experienced by marginalized and culturally very different communities, including First Nations people—be specifically traced to a history of enslavement, colonization and the resulting discrimination, which is tantamount to racism, to which African-Canadians are subjected?

Objectives

The following objectives were determined:

Objective 1: To demonstrate that the psychiatric and psychosocial services currently being offered to African-Canadians are inadequate.

Objective 2: To determine the impact of enslavement, colonization, and racism has on the identity and adaptation of African-Canadians, as well as the dysfunctional aspects of Canadian multiculturalism.

Objective 3: To develop a new service model for prevention and treatment capable of responding to the reality and needs of African-Canadians.

Funding

Initial funding and logistical support from both the psychiatry department of Montreal's Jean-Talon Hospital and Toronto's Centre for Addiction and Mental Health (CAMH) were crucial in the preparatory stages.

Health Canada saw the merits of the project and advanced a grant of $50,000.00. The Mental Health Division of Quebec's Health and Social Affairs Ministry, on their part, provided a grant of $18,400.00. Heritage Canada eventually came through with a grant of $94,223.00.

The Canadian Race Relations Foundation (CRRF) was an early participant in the project. Subsequently, various institutions expressed their support, among them: the City of Montreal's Intercultural Affairs Division, the Quebec Ministry of Health (Mental Health Branch), the University of Quebec in Montreal (Research Centre on Immigration, Ethnicity and Citizenship), the Ontario Black Association, the Black Coalition of Quebec, the Jamaican-Canadian Association, and Nova Scotia's Association of Black Social Workers.

UNESCO's History and Culture section not only issued an invitation for a presentation of the project in Paris, it also gave its support and pledged to work with the group. Approximately one third of the work was actually accomplished on a voluntary basis.

Strategies

From the outset, it was agreed that the process would not be assigned to a "panel of experts." Instead, an African approach "to reflect the wisdom, knowledge and know-how of African traditions," that is, a process of community consultation, of collective production and collective ownership, was adopted. Community organizations in Montreal, Toronto and Halifax were consulted through focus group and their active participation greatly contributed to the design of the project.

A symposium, held at the Far Hills Inn, in Val Morin, Quebec, from 27–29, September, 2006, drew participants from Toronto, Montreal and Halifax, as well as from the United States, the Caribbean, Europe and Africa. It was remarkable for representing inter-professional, interdisciplinary and intercultural diversity, as well as different personal and "professional" backgrounds, various categories of age, gender, ideological, spiritual and religious affiliations, and a wide range of socio-economic strata.

The focus on the impact of enslavement, colonization and racism on the identity and health of African-Canadians, in the midst of the dysfunctional Canadian multiculturalism, is considered by the committee to be one of the most original and significant aspects of the project, as it:

a) approaches clinical concerns from an historic and political perspective;
b) argues a linkage between the different forms of deviance observed among African-Canadians (vandalism, petty crime, substance abuse, psychosis, mystical escapes) and the dysfunctional aspects of Canadian multiculturalism.

Its impact upon both the group, in the breakdown of family and social networks, and also upon the individual is demonstrated in the concept of the ***post-traumatic slave syndrome***, where current attitudes and behaviours are traceable back to the sequellae of slavery, especially the phenomena of low self-esteem, racist socialization and the ever-present "black rage."

The process begins with slavery (particularly in the 15th to 17th centuries) and is transmitted genetically (the amygdala, neuropeptides) and even sometimes in the descendant's memory.

This heritage is evident sometimes from birth, or in the earliest years of the child's development (congenital abnormalities, autism, hyperactivity, etc.).

But it shows up most often at puberty, a period during which, irrespective of culture, impulses are biologically reactivated, ones that contemporary cultures are generally at a loss as to how to accommodate.

This reactivation drive occurs more intensely among African-Canadians, taking the form of unbridled sexuality and/or "incomprehensible" aggressiveness.

Attempts by individuals to deal with this burst of impulses can manifest itself in "alloplastic" behaviours, turning the impulses outward (vandalism, theft, murder, etc.) and in "autoplastic" behaviours, turning inward (shyness, pseudo-retardation, psychosomatic disorders, substance abuse, schizophrenia, suicide).

The New Approach

The work done over the last three years by the focus group participants, the members of the Program Committee and the Think Tank participants did not reach any consensus on new models of services but succeeded in formatting principles on which a new approach can be developed.

Any preventive or curative effort targeting African-Canadians from now on will clearly have to incorporate:

1) The distinctiveness of the traditional African reference systems, with its emphasis on ancestral, spiritual, familial and social networks and the collective entity, versus Western-style individualism.

2) The holistic, energy and environment-based approach to health and disease.

3) The importance of the body, its particular primal energy and its rhythm.

4) The effects of daily acts of oppression that the majority of African-Canadians live under, especially when oppression takes the form of racism.

5) The significant and cumulative impact of multiple incidents of past oppression and trauma on contemporary problems and issues.

Recommendations for Future Action

The Committee is of the opinion that the preliminary spadework begun during this phase of the project has resulted in planting a seed that future hands will bring to germination. From an African perspective, which is closer to Eastern traditions than Western, the most important aspect is not the "performance" but the "process," and that process has surely been set in motion. The project is a vibrant work in progress, albeit not without flaws.

Where this project has fallen short of its goal, that deficit might be due in part to the delayed impact of enslavement, colonization and racism, which continues to form division as well as feed self-destructive tendencies within communities of African ancestry. Such a reality mandates the urgent development of strategies to promote cohesion within these communities.

In assessing steps to be taken in the next phase of the project, it is important to identify and invite participation from individuals and institutions genuinely interested in furthering the scope and legacy of the project. Key to its viability and success would be securing long-term commitment and funding for the next and subsequent phases.

A reassessment of participant eligibility criteria is needed, particularly in light of the pressures exerted on the Program Committee on a number of occasions to exclude certain participants, in particular on the basis of their skin colour.

It should be mentioned that, during the Think Tank, questions about the role of traditional healers, and in particular their actual involvement in the health services, were raised but not explored further. However, this might be worth examining in greater depth, given the call for the establishment of a centre for clinical implementation of the approach and the "model."

In this context, a discussion on the terms, conditions and timing of representations to the initiators of the Kirby Report on Canada's mental health practices and policies would also be timely.

Finally, the expansion and periodic updates to this report, as the next phases are implemented, will culminate in keeping with its original spirit and intent.

Preamble[1]

As the *rapporteur*s and writers of this report, we have attempted to chart the progress of an initiative undertaken in 2002 by a small core group, irrespective of academic and social status, personal background, geographic location, and skin colour (Note 2). We began looking into the specific nature of the impact of enslavement, colonization and racism on the identity and health of African-Canadian distress and the light that it might shed on "Canadian multiculturalism."

This small core grew and developed into a broad network of individuals idealistic enough to "dream in Technicolor," in an attempt to develop methods for an "alternative" interpretation of this situation, and to devise new tools for approaching it.

This document definitely reflects the values, observations and interactions of the writers (Note 3). However, it is our hope that readers, including participants in the September 2006 Think Tank, will approach it as a work in progress and join us in the project, particularly as they share similar goals.

[1] All activities in this project were conducted in English and French. One of the present-day effects of colonization is that it forces us to work in languages that do not correspond to the profound energy of African-Canadians. Thus, for lack of an alternative, we have used the term "participant" to refer to both men and women.

The Stages Involved In Planning And Carrying Out The Project[2]

I – Initial Findings and Hypotheses

The idea for this project is based on two findings made by people who work on a daily basis in Canadian correctional and health services. These findings are:

a) The over-representation of African-Canadians in involuntary services (detention centres, forensic psychiatric centres, youth centres, etc.).

b) Their under-representation in voluntary services (outpatient psychiatric clinics, addiction services, etc.).

The project initiators started from these two findings, which we will strive to document more fully below, and came up with two questions.

a) Could the relative position of African-Canadians in Canadian society be exacerbated and perpetuated by the deficiencies in the preventive and curative services that are available to them?

b) Could these same deficiencies—which incidentally have been experienced by marginalized and culturally very different communities including First Nations communities—be specifically traced to a history of enslavement, colonization and the resulting discrimination, which is tantamount to racism, to which African-Canadians are subjected?

II – Definition of Objectives

Project objectives emerged from the informal discussions that began in the summer of 2002 and gradually became more precise. These objectives are:

Objective 1: To demonstrate that the psychiatric and psychosocial services that are currently available to African-Canadians are inadequate.

Objective 2: To determine the impact of enslavement, colonization, and racism on the identity and adaptation of African-Canadians, as well as the dysfunctional aspects of Canadian multiculturalism[3].

Objective 3: To develop a new service model for prevention and treatment that is capable of responding to the reality and needs of this population.

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[2] We feel that it is important to report on the different stages of the project as objectively as possible in order to:

a) inform associates who joined us later in the process and who might not have understood that the September 2006 Think Tank was just one step in a long process

b) reduce the risk of misinformation and neo-colonial co-opting or appropriation of the project

c) bring forward information that could provide new insights into the dynamics of African-Canadian communities and the impasse that Canadian multiculturalism in its present form has reached.

[3] Dysfunctional aspects of Canadian multiculturalism, for the purposes of this report, relate to historical factors (specifically slavery, colonization, and policies enacted over the years) that have consistently excluded African-Canadians from mainstream society by shoring up a multiculturalism of dominance rather than a multiculturalism of mutual enrichment amongst equals.

III – Search for Support and Associates

In February 2004, the Department of Psychiatry at Jean-Talon Hospital in Montreal and the Centre for Addiction and Mental Health (CAMH) in Toronto signed a co-operation agreement and instructed C. Sterlin and A. Dérose to recruit associates and set up a Steering Committee and an Advisory Committee (Appendices I and II).

In May 2004, the Canadian Race Relations Foundation (CRRF) became the first institution to support the project and steered the team through its early stages.

In the months following, a number of institutions expressed their support, in particular the City of Montreal's Intercultural Affairs Division, the *Ministère de la Santé et des Services sociaux* (Quebec Ministry of Health and Social Services) (Mental Health Division), the *Université du Québec à Montréal* (Research Centre on Immigration, Ethnicity, and Citizenship), the Ontario Black Association, the Black Coalition of Quebec, the Jamaican-Canadian Association, and others.

In December 2004, UNESCO's History and Culture Sector invited us to Paris to present the project, gave us its support, and pledged to work with us although it was unable to contribute financially.

In December 2005, Nova Scotia's Association of Black Social Workers joined the project.

IV - Search for Funding

We should mention first off that most of the work accomplished since 2002 has been done by volunteers[4]. Logistical support and a modest amount of funding from CAMH and Jean-Talon Hospital helped us through the preparatory stages.

A. Dérose and T. Wereley undertook negotiations with federal institutions. Representatives from Health Canada were quick to see the merits of the project and granted the sum of $50,000.00.

Negotiations with Heritage Canada were more laborious, particularly when it was suggested that we delete the project's subtitle (Enslavement, Colonization, Racism, Identity and Mental Health). The matter was finally resolved in September 2005 with a grant of $94,223.00, to which a number of conditions were attached.

One of the main difficulties encountered in negotiating with two federal ministries was the fact that while both approved the project, each felt that it fell within the jurisdiction of the other. When asked, "Does your project fall under Health or Culture?" we had to choose. This Cartesian way of thinking was obviously inconsistent with an African perspective. It was especially unacceptable as we were firmly convinced that the health problems of African-Canadians were due in part to Canadian intercultural dynamics.

The financial contribution from the Mental Health Division of Quebec's Health and Social Services Ministry was easier to negotiate and, in May 2006, we received a grant of $18,400.00.

Quebec's Ministry of Immigration and Cultural Communities declined our invitation to participate[5].

[4] Some of the project's *animateurs* (leaders or facilitators) were wondering whether we were not unconsciously emulating a slave economy. The first draft of the Phase I report was produced in April 2007 by the members of the Program Committee (P. Annoual, G. Bibeau, C. Marshall, C. Sterlin) and was modified later into its present form.

[5] It is ironic that this refusal reached us shortly after publication of "Task Force Report on Full Participation by Black Communities in Quebec Society" by the *Ministère de l'immigration et des communautés culturelles* (Quebec Ministry of Immigration and Cultural Communities).

V – Strategies to Achieve our Objectives

From the outset, we decided not to hand over the process to a "panel of experts." Instead, we insisted throughout on making the process a collaborative, "African-style" process, with a collective production and collective ownership. This explains the importance that we placed on this collaborative process, from the project design stage right on to the consultations with the community in the form of focus groups, supervised by Clem Marshall of Toronto.

The project was designed in two phases:

Phase I:

- The identification and mapping out of individuals and groups concerned by the project in Canada and elsewhere.
- A review of the relevant literature.
- Consultations with community agencies and focus groups.
- A closed Think Tank with the three objectives.
- The production of a preliminary report.

Phase II:

- Based on the preliminary report, consultations with the same agencies as in Phase I.
- Updating the report.
- Organizing a symposium open to the general public on the "final" version of the report.

Overall, the various stages of Phase I preceded as planned, in particular, the mapping-out process and the focus groups, which were held in Toronto, Montreal and Halifax (Appendix III).

Feedback from the initial consultations and the two videoconferences with the Advisory Committee members were invaluable to the Program Committee in designing both the structure and the content of the Think Tank. As recommended by the Advisory Committee, a group of young people from each of the three cities was invited to collaborate throughout the Phase I and to participate in the Think Tank.

In the fall of 2005, Pascale Annoual and Clem Marshall were actively involved in finding national and international associates, particularly in preparation for the Think Tank.

In December 2005, under the supervision of G. Bibeau and C. Sterlin, an anthropology student, worked on a methodology for Objective 1 and did bibliographic research to that end.

In the spring of 2006, Montreal illustrator and visual artist Marie Denise Douyon did a painting of her interpretation of the themes of the project.

VI – A Key Moment in Phase I: The Think Tank, September 27-29, 2006

Conceptualization of the Think Tank

It was clear to the Program Committee that this gathering had to make a clean break with the usual style of conference[6] in order to reflect the wisdom, knowledge and know-how of African traditions.

Essentially, it had to:

- create a setting conducive to a joyful, collective undertaking

[6] In spite of repeated reminders to the contrary, some of the Think Tank guests approached the gathering with traditionally Western expectations (a cut-and-dried agenda, lecture-style presentations followed by a question period, etc.). They were mainly bothered by the lighthearted and spontaneous aspect of the gathering and by the importance attached to ancestors, spirits and rituals.

- avoid the usual hierarchies (therapist/patient, lecturer/audience, academic/uneducated, etc.)
- respect the inter-professional and intercultural diversity found within black communities across Canada
- ensure that its achievements were not perverted or exploited for commercial purposes.

In order to send a clear signal of this break with conventional conference style, the opening session included a wonderful cultural celebration with:

- A welcoming ceremony in the Kuswenta tradition by a First Nations representative[7]
- An invocation to the ancestors, spirits, and gods of Africa that reflected an African aesthetic while remaining mindful of the movements, rhythms and energies of the participants.

The Think Tank

The criteria for selecting participants (Appendix IV) were generally adhered to. Most of the invitees responded to our request that they provide us with advance notice of their specific area of interest and possible contribution to the three objectives, which made it easier for session moderators to manage the give-and-take of the discussions. In spite of significant resistance, the Program Committee was determined to see the process through; the conference was held at the Far Hills Inn, in Val Morin, Quebec, September 27-29, 2006.

Support and logistical arrangements, provided primarily by Pascale Annoual and her assistants, were instrumental in setting the tone for this gathering that had been chosen at the outset (i.e., staying close to the objectives while adjusting the strategies to the context and the energy of the groups). We attempted, with mixed success, to make the program a tool, rather than a constraint (Appendices V and VI).

A competent and flexible team of interpreters helped to keep the English and French language groups communicating.

No written report is able to do justice to the spirit of the gathering, the essential core of which was non-verbal.

An audiovisual recording of the Think Tank was produced by Emil Kolompar and delivered on December 15, 2006, to the *Institut interculturel de Montréal* documentation centre, during a ceremony to honour and thank the African deities who had accompanied us during this process. Anyone who is interested in our project may consult these documents.

The Program Committee feels that, despite its limitations, the Think Tank made a significant contribution to the project's three objectives.

[7] "Kuswenta" is the Mohawk term for all the peace alliances that have been entered into from the moment of first contact between the Mohawk and Western nations. This ceremony marked the willingness of "Africans in America" to meet with members of the Turtle Island network in a spirit of intercultural brotherhood far remote from any concept of Western "conquest."

Participants at the Conference on

Developing and Implementing a Model to Improve Mental Health Services to African Canadians

Val-Morin, Québec, Canada

September 27–29, 2006

1 **Wanda Bernard**, PhD • Director, School of Social Work • Dalhousie University • Halifax, Canada
2 **Sandy Miller**, MSW • Student, person with psychiatric patient experience • Halifax, Canada
3 **Baba Koumaré**, MD • Psychiatrist • Mali
4 **Zab Maboungou**, PhD • Choreographer, professor of philosophy • Montréal, Canada
5 **Miriam Rossi**, MD • Adolescent medecine practitioner • Toronto, Canada
6 **Monique Dauphin** • Senior, community worker and traditional practitioner • Montréal, Canada
7 **Carlo Sterlin**, MD • Transcultural Psychiatric Clinic • Hôpital Jean-Talon • Montréal, Canada
8 **Jaswant Guzder**, MD • Psychiatrist, Family and Adolescent Program • Jewish General Hospital • Montréal, Canada
9 **Louise Adongo**, MA • Youth representative • Halifax, Canada
10 **James Homiak** • Specialist, Rastafarian • Smithsonian Museum • Washington, DC, USA
11 **Joy Degury Leary**, PhD • Social worker • Oregon, USA
12 **George Rodriguez** • Percussionist • Montréal, Canada
13 **Florise Boyard**, MA intern • Youth representative, drama therapist • Montréal, Canada
14 **Hirut Eyob** • Youth caucus leader • Montréal, Canada
15 **Dion Hodges** • Drug and alcohol prevention worker • Halifax, Canada
16 **Jean Pierre Muyard**, MD • Psychiatrist, psychoanalist and homeopath • Paris, France
17 **Laënnec Hurbon**, PhD • Anthropologist, professor • Haïti
18 **Caroline Knowles**, PhD • Sociology professor • England
19 **Fatimah Jackson**, MA • Youth representative • Toronto, Canada
20 **Kaye Johnson** • Race Relations, Cross Cultural Understanding and Human Rights Coordinator • Halifax, Canada
21 **Akua Benjamin**, PhD • Ryerson University • Toronto, Canada
22 **Nadine Mondestin** • Youth and administrative support worker • Montréal, Canada
23 **Gilles Bibeau**, PhD • Anthropologist • Université de Montréal • Montréal, Canada
24 **Frederick Hickling**, MD • Psychiatrist • Jamaica
25 **Antoine Dérose** • Project Coordinator • Centre for Addiction and Mental Health • Toronto, Canada
26 **Cécile Rousseau**, MD • Ethnotherapist and psychiatrist • Montreal Children's Hospital • Montréal, Canada
27 **Karlton Robinson** • Person with psychiatric patient experience • Montréal, Canada
28 **Audley Coley** • Dancer, person with psychiatric patient experience • Montréal, Canada
29 **Pascale C. Annoual**, MA • Art therapist, project communication officer • Montréal, Canada
30 **Joël Des Rosiers**, MD • Psychiatrist, author • Montréal, Canada
31 **Zakaria Rhani**, PhD candidate • Ethnologist, traditional Maroccan healing practitioner • Marocco / Montréal, Canada
32 **Kwasi Kafele** • Director of Diversity • Centre for Addiction and Mental Health • Toronto, Canada
33 **Billy Two Rivers** • Mohawk Elder • Kahnawake, Canada
34 **Llewellyn Joseph**, MD • Psychiatrist • Toronto, Canada
35 **Waleed Abdoul Hamid Kush** • Drummer • Toronto, Canada
36 **Clem Marshall** • Project consultant, focus group committee chair • MangaCom Inc. • Toronto, Canada
37 **Jacques Newashish** • Cultural worker with youth • Atikamekw Nation, Canada
38 **Sushrut Jadhav**, MD • Psychiatrist • London, UK
39 **Lucien Hounkpatin**, MD • Ethnotherapist, director • Centre G. Dévereux • Paris, France
40 **Clement Grant** • Emergency orderly • Montréal, Canada

Preliminary Results of the Phase I Process

To what extent did the process initiated in 2002 contribute to the achievement of the objectives?

Objective 1: Demonstrate that the psychiatric and psychosocial services currently available to African-Canadians are inadequate.

The methodology for addressing this issue was essentially developed by one of our "external" associates, Patrick Cloos. He initially documented the over-representation of African-Canadians in involuntary services and conducted a review of the literature. He then went on to offer possible explanations for this over-representation (Appendix VII).

Over-Representation Of African-Canadians In Involuntary Services

A few statistics for the province of Quebec:

- 25% of clients in Quebec's youth centres and in the Batshaw Youth and Family Centres are African-Canadian
- 30% of the parents of Montreal's Youth Centre clients who were born outside Canada are from Africa and the Caribbean
- in one specific catchment's area of Montreal, where blacks represent 13.3% of the population, 27% of patients placed under the jurisdiction of the "Tribunal Administratif" are black.

A few statistics for Canada:

- Blacks represent 2% of the total population
- Blacks represent 5% of the prison population
- There are no statistics available, but psychiatric forensic units in Southwestern Ontario (including CAMH), based on anecdotal information, seem to have a disproportionately high number of men of colour, including African-Canadian men.

Possible Explanations For This Over-Representation

A) The racist interpretation: "They are genetically inferior and illness prone."

B) The intercultural interpretations:

1) The dominant system of "Canadian multiculturalism" forces West-centric standards on them. Any deviation from these standards is therefore considered pathological and/or dangerous.
2) Some of the natural manifestations of their African culture and life experience are interpreted as "pathological."
3) The very dynamic of Canadian multiculturalism makes them vulnerable (marginalization, racism, poverty, unemployment, etc.).
4) Their attempts to adapt to the oppressive system are labelled as "pathological" (gang membership).
5) To this day, they carry the debilitating sequellae of past trauma (Objective 2).
6) The services that are available to them are deficient because these services do not take into account their "reality."[8] The services themselves are potentially pathogenic (cf., the Clinical Case Study). They can be characterized by:

[8] Statements made during the focus groups confirmed this general perception of inadequacy.

- an over-hasty diagnosis of schizophrenia
- virtually immediate recourse to the judicial system
- a rush to administer massive doses of neuroleptics and other drugs.

Objective 2: Determine the impact of enslavement, colonization and racism on the identity and adaptation of African-Canadians and on the dysfunctional aspects of Canadian multiculturalism.

The committee considers this objective to be one of the most original aspects of the project:

a) Approaching clinical concerns from a historical and political perspective.
b) Arguing a link between the different forms of deviance observed among African-Canadians (vandalism, petty crime, substance abuse, psychosis, and escape into mysticism) and the dysfunctionality of Canadian multiculturalism[9].

We feel that this approach could help to give African-Canadians a "reality check," i.e., a check with the reality of their daily lives that is generally hidden from view by the dominant ideology.

Limits on our time and resources made it impossible to explore these possibilities as deeply as they warrant. A few themes did emerge however, in particular, thanks to the work of L. Hurbon, J.G. Leary, and J.P. Muyard.

Impact on the Group

I – On African-Canadians

- Suppression of symbolic systems (L. Hurbon);
- Breakdown of family and social networks;
- Elimination and/or rejection of the father's relevance (J.P. Muyard);
- Propagation of a social dynamic leading to the "implosion" of black communities, which then direct the aggression they cannot display toward the dominant system inwards, against themselves (F. Fanon, W. Bernard, J.G. Leary);
- Dismissal/rejection of forms of spirituality inherent in African traditions and appeals instead to Christian denominations with their potential for alienation;
- Attempts, mainly by young people, to create new networks for themselves (gangs) and new symbols (G. Bibeau, J. Homiak).

II – On Canadian society as a whole

- Enslavement and colonization have contributed to determining the dynamics of Canadian society and to maintaining racism and a variety of ways of excluding the contribution of African-Canadians from the process of shaping a multicultural society.
- Enslavement and colonization have also contributed to a multiculturalism of dominance rather than a multiculturalism of mutual enrichment amongst equals.
- It can be hypothesized that among Canadians of European origin, a mechanism for denying their pro-slavery past has contributed to:
    - maintaining an unconscious guilt complex
    - "cognitive dissonance," particularly in the field of education.

[9] Dysfunctional aspects of Canadian multiculturalism, for the purposes of this report, relate to historical factors (specifically slavery, colonization, and policies enacted over the years) that have consistently excluded African-Canadians from mainstream society by shoring up a multiculturalism of dominance rather than a multiculturalism of mutual enrichment amongst equals.

Impact on the Individual

Colonized peoples have been described in a wide range of ways, particularly over the past three decades (A. Memmi, F. Fanon).

J.G. Leary's concept of ***posttraumatic slave syndrome*** has been particularly useful with the approach that we have taken. Leary attempts to demonstrate that the attitudes and behaviours of American blacks are related to the sequellae of slavery, especially the phenomena of low self-esteem, racist socialization, and the ever-present "black rage."[10]

Future development of this project will make it possible to articulate this portrait with J.P. Muyard's hypotheses on the ways in which the impact of slavery is transmitted.

The Transmission Process (J.P. Muyard, J.G. Leary, C. Sterlin)

First Phase: Enslavement, particularly in its most radical form in the 15th to the 17th centuries, snuffed out/extinguished the life instinct of those who were enslaved.

This assault was not just "psychic" (J.P. Muyard). It also reshaped the energy body of the slave and left permanent traces:

- always in the slave's body (the amygdala, neuropeptides)
- sometimes in the slave's memory.[11]

Second Phase: These traces alter the genetic heritage of the father-as-impregnator but they especially alter the biology of the mother-as-womb. She transmits these traces unconsciously to the fetus.

Third Phase: This heritage is sometimes evident from birth or in the early years of the child's development (congenital abnormalities, autism, hyperactivity, etc.)

Fourth Phase: This heritage most often shows up at puberty. This is a time when, irrespective of culture, there is a biological reactivation of impulses that contemporary cultures generally do not know how to accommodate.

Understandably, this reactivation occurs more intensely among African-Canadians and takes the form of unbridled sexuality and/or "incomprehensible" aggressiveness.

An individual's attempts to deal with these impulses can manifest as:

- "alloplastic" behaviours (vandalism, theft, murder, etc.);
- "autoplastic" behaviours (shyness, pseudo-retardation, psychosomatic disorders, substance abuse, schizophrenia and suicide).

[10] It would be appropriate to delve more deeply into the disparity between G. Bibeau's view (i.e., that suicide among African-Canadians is rare) and J.G. Leary's hypothesis that some murders among young African-Canadians are disguised suicides (post-traumatic slave syndrome, p. 131). In the same vein, the phenomenon of conjugal and intra-family violence should also be explored in greater depth within this population.

[11] Our bodies remember events that we have forgotten. (C. Sterlin)

Objective 3 is Reframed

Originally worded as "to develop a new service model, etc.", the group approach adopted for the Think Tank sessions resulted in different wording, i.e., **"Developing a new approach and new models for preventive services for African-Canadians."** This revised approach must be rooted in the "specific genus of African cultures" while also taking the impact of interbreeding into account (F. Boyard, G. Bibeau). From the range of models proposed, we selected only those that were compatible with the principles of the new approach.[12]

Principles of the New Approach

In the future, prevention or treatment services for African-Canadians must take into consideration:

1) The distinctiveness of traditional African belief systems, in particular:
    - The importance of the "invisible" realm[13] and the role of ancestors, spirits, and gods (M. Dauphin, B. Two Rivers)
    - Notions of the individual that are not reducible to a strict separation between mind and body (B. Koumare, L. Hurbon, C. Sterlin)
    - The close connection between human beings and the natural environment and their concern with living in harmony with its rhythms
    - The importance of the family, the social network, and the collective being versus Western-style individualism (K. Johnson)
    - The importance of knowledge not sanctioned by Western science (L. Hounkpatin)
    - The holistic-, energy- and environment-based approach to health and disease.

2) The importance of the body, its unique experience of energy, its experience of rhythm (Z. Maboungou), and its innate skills in self-expression (A. Coley, W. Hamid Kush, G. Rodriguez.[14]

3) African cultures' factual knowledge and procedural knowledge of pain, suffering, sickness, and death.

4) The hard reality of the oppression in which the majority of African-Canadians live every day, especially when this oppression takes the form of racism.

5) The impact of past oppression and trauma on present problems and issues (see Objective 2).

[12] We have only listed the models that were available to us during this phase of the project. There are certainly others that reflect the principles of this new approach (e.g., the model developed by Dr. Eric Gbodoussou at Senegal's Fatik Centre). They will eventually have to be incorporated into future updates of this report.

[13] A real intercultural clinic would have to avoid automatically interpreting references to the "invisible" world as delirium. (J.P. Muyard)

[14] Invited to say a few words at the closing session, G. Rodriguez improvised a drum solo that was totally untranslatable even in African languages.

New Models for Intervention

Preventive Care Models

1) Through community agencies, offer people, in particular, young people, the opportunity to familiarize themselves with the cultural roots of their parents and ancestors:
    - their spiritual roots (M. Dauphin)
    - their expressive and artistic roots (Z. Maboungou, A. Coley).

2) Create birthing centres for African-Canadian women (J.P. Muyard), designed to limit the risks of transmitting trauma across generations through discussion groups for pregnant women from the fifth month of pregnancy on (Appendix VIII).

3) Organize activities in the schools involving students and teachers to limit the damage done by learning "cognitive dissonance" (J. Guzder, C. Rousseau, C. Marshall) and to deconstruct the myths of the Western world (F. Hickling). Organize intercultural art workshops and storytelling in the classroom and in community centres (C. Rousseau).

4) Develop programs to improve parenting skills (L. Joseph) based on African-centred values (W. Bernard, M. Rossi, A. Benjamin).

5) Develop a "create a world" program (F. Hickling) by inviting groups of nine- and 10-year-old children from disadvantaged neighbourhoods to eat a healthy meal, imagine a world in which they would like to live, and "act it out."

6) Create homes for teens of colour (J.P. Muyard, Appendix VIII). Such safe places will allow for socialization that is in line with their cultural roots, promoting a wide range of modes of expression and ultimately allowing for an initiation process. This environment might lead to healthier management of the gang phenomenon by reinforcing constructive identity building (G. Bibeau).

7) Develop strategies to promote cohesiveness/empowerment among African-Canadians (J. Homiak):
    - reconstruct and disseminate the "true" history of blacks in Canada (including Quebec's own history of slavery)
    - create the conditions for developing a "myth" of slave deportation through the lives and work of heroes in the "Black pantheon," irrespective of the cultures and languages imposed on them by colonization: Mackandal, Toussaint-Louverture, Malcolm X, Martin Luther King, Harriet Tubman, M. Garvey, Rosa Parks, Mandela, etc.

Treatment Models

1) Models for managing initial, psychotic-like episodes in the 18 to 25 year age group.

Many participants (D. Hodges, J.P. Muyard, A. Coley, G. Grant) stressed the urgency of developing new ways of treating these young people.

To be avoided are:

- the cold, alien and frightening setting of hospital emergency departments
- over-hasty diagnosis of schizophrenia
- massive reliance on forced drug therapy.

The new models would combine:

- appropriate intake
- support and follow-up
- accompaniment
- culturally adapted listening
- empowerment.

The participants had differing opinions on the role of medication.[15]

The Muyard Model[16]

A specific treatment protocol for use in emergency departments and *centre local de services communautaires* (CLSCs) with young people from an Afro-Caribbean background:

- caution in use of the DSM-IV guidelines
- caution in the use of massive sedation
- active involvement of family members and community resource persons in order to correctly interpret the meaning of "symptoms"
- placing high priority on all forms of nonverbal communication.

2) The "Cultural Formulation" Model developed by J. Sushrut (London) (Appendix IX)

This model gives priority to the client's version of their situation and their "problem" in their own words and from their own cultural perspective. The health care team works intensively to decode this story in order to adjust its interpretation of the set of symptoms and treatment.

3) The "Ethnopsychiatric" Model developed by T. Nathan and L. Hounkpatin

In this model, there is a collective construction of the "meaning" of the individual's distress and its management through a group-based strategy involving therapists of various ethnic backgrounds, the client's own network and, above all, a "mediator" fully grounded in the client's culture. The "client network" inherently includes their ancestors, spirits, and deities.

It should be mentioned that during the Think Tank, questions about the role of traditional healers, in particular their actual involvement in health services, were raised but not explored further.

4) Role Play Models

a) The therapeutic Koteba (B. Koumare, Mali)

Inspired by the traditional Koteba of the Bambara tribe, the therapeutic Koteba session opens with singing and dancing involving actors, the health care teams and the patient. The group leader then invites the patient to improvise the role of village chief (Dougoutigui), thereby triggering potentially therapeutic role-play sequences.

b) The "Psychohistoriographic" Approach (F. Hickling, Jamaica)

This approach deconstructs paradigms of the dominant society (e.g., slavery and colonization viewed as manifestations of the European imperial fever, capitalism viewed as perversion, etc.) (Appendix X).

[15] The ethno-psycho-pharmacology research headed by K.M. Ling may pave the way for new psycho-pharmacological protocols.
[16] J.P. Muyard has daringly strived to incorporate the work of P.D. McLean, H. Laborit, and J. Lacan into his own thinking.

Strategies are developed for empowering “patients” through bodily expression, musical improvisation, dramatic improvisation, etc.

5) Art Therapy Models

Art therapy workshops take into account Afro-centric cultural elements (P. Annoual). Within a safe and predictable therapeutic framework, the workshops are designed to enable participants to explore, find meaning, express themselves and communicate dynamic elements of identity that are personally relevant. These group workshops take into consideration differences, similarities, mechanisms of exclusion (stereotypes and racism), mechanisms of inclusion and social networks.

Clinical Case Study

The following case is designed to contrast conventional practices and practices of the kind that our approach would give rise to.

The Context

This vignette takes place in the Montreal neighbourhood of Hochelaga on Thursday, November 7, 2009, in an apartment block with 18 units. Five black Haitians have been occupying a three-and-a-half-room apartment on the fourth floor for some months. The neighbours (mainly French-Canadian and Christian Latino) view them as a (married?) couple in their thirties and three other younger blacks. Sporadically and for varying periods of time, other blacks come and stay. The couple refers to them as "cousins."

Act I

Scene 1: 11:00 p.m. The neighbours become intrigued, then bothered, by strange noises coming from the "Haitians' place": heavy footsteps on the floor, banging on the walls, grunting, singing, etc.

Scene II: 11:27 p.m. The noises get louder and the concerned neighbours see a young black man leave the apartment and dash into the corridor, leaping from side to side, making faces and incomprehensible "snarling" sounds.

Three Latinos, who are Jehovah's Witnesses, dare to approach him, trying to calm him down and bring him back to his apartment. The young man does not even seem aware of them. His eyes are wild and unfocussed. He is gesticulating, smiling and growling. His whole body is sometimes convulsed in tremors and he makes "obscene" thrusting motions with his hips.

A French-Canadian neighbour observing the scene decides to call 911: "There is a black guy here who is smashing everything up!"

Scene III: Two armed policemen (one a black male, the other a blond female) approach the young man, using the techniques they learned at the Nicolet Police Academy. They order him not to move. The "black guy" starts to tremble from head to toe, shaking his shoulders and rolling his hips. The male policeman overpowers him while the female constable talks to the couple.

Scene IV: The couple argues. The man thinks that that should be the end of it, that things will work themselves out, especially if they "consult" the voodoo priest in apartment 17, 363 Beaubien.

The woman (a Jehovah's Witness) "knows" that those stupid, lewd movements are a sign that the man is possessed by the devil and, threatening her spouse, demands that the young man, Alcius, be taken to the hospital.

Act II: A Teaching Hospital

The "Scientific" Approach	The Alternative,"Dream a Clinic," Approach
Friday, 1:00 a.m.: In the emergency department, the "patient," accompanied by a cousin, is gesticulating wildly in the waiting room.	Friday, 1:15 a.m.: A group of "decolonized" individuals (Haitian, Jamaican, French-Canadian, Beninese, French from France) enter the emergency department, "calm down" the nurses and security guards, and talk to Alcius.

1:35 a.m.: After a brief discussion in a mixture of French and Creole with the cousin, the nurses, and the patient, the emergency physician prescribes isolation and an injection of Haldol.

He also writes out a requisition for a psychiatric consultation, noting on the requisition, "Bizarre behaviour, agitation, aggressiveness. Schizophrenia?"

The patient yells and bangs on the door of the isolation room for a good part of the night.

9:00 a.m.: A consulting psychiatrist of Lebanese background confirms the schizophrenia diagnosis, orders institutionalization, and prescribes medication.

Friday, November 8, and Saturday, November 9

After a short period of protests and attempts to escape, the patient gradually adjusts to the department routine, takes his medication, goes for occupational therapy, etc.

They leave the emergency department and take Alcius to a home for black youth patterned after the new models (Muyard, Nathan, Hickling).

In a safe setting, Alcius can now give himself freely over to gesticulating, singing, twisting his shoulders, and rolling his hips.

Gradually, he voices his "narrative," reconnecting with his history, culture and primal energies.

9:00 a.m.: A culturally competent psychiatrist invites the cousin to accompany him into the isolation room. Alcius goes into a trance, is possessed by the god Ogun, and finally falls into a deep sleep.

10:15 a.m.: Two other cousins show up. Lengthy discussions with the psychiatrist. After careful negotiation, Alcius agrees to an injection of 5 mg Haldol to calm down.

Saturday November 9, 8:00 a.m.: After a quiet night, Alcius is re-evaluated with input from the cousins and discharged with a slip for an appointment in the outpatient clinic (which he doesn't go to).[17]

February 2010 (three months later)

Clinical progress is confirmed. The patient is quiet, polite with staff, takes part in group outings, etc. Everyone considers him greatly improved, even though he is uncommunicative and somewhat apathetic.

Alcius, back in his Hochelaga apartment, drops by the black youth centre regularly. He has regained his vitality, is discovering his artistic talents (as dancer, musician, singer and songwriter).

He will soon go for training as a community worker.

ACT III: February 2015 (five years later)

Alcius is forcibly re-hospitalized on three separate occasions and is on welfare. Drug consumption and suspected trafficking. Shoplifting and hanging out with gangs.

He is placed under public curatorship.

Alcius works for a community agency in Toronto as a street worker for troubled youth. He regularly organizes cultural animation sessions in centres for black teens in Toronto, Montreal, and Halifax.

[17] The psychiatrist wanted to see Alcius again because he had enough clinical experience to know that the early signs of psychosis can take on all sorts of atypical forms, including "false possession".

In six years, the cost of his maintenance, support and “treatment” are estimated at approximately $700,000.00, not including the social and cultural costs.

In January 2016, Alcius plans to take part in the Annual Festival of Traditional Vodun Religions in Cotonou (Benin).

Evaluation Of The Phase I Process

The Program Committee hopes this report adequately reflects the work that has been accomplished on this project, in terms of both its strengths and its weaknesses.

The strength of our approach is essentially its originality. We have achieved a “world première.”

We have assembled a wide range of participants to comment on the impact of enslavement on the health of African-Canadians. These participants:

- represent a variety of geographic areas (Quebec, Ontario, Nova Scotia, U.S.A., Haiti, Jamaica, France, Great Britain, Benin, Mali, Morocco, Turtle Island, etc.)
- demonstrate widely ranging personal and professional as well as social and economic backgrounds
- reflect tremendous diversity in terms of their age, gender, and ideological, spiritual, and religious affiliations.

We have demonstrated a correlation between African-Canadian health issues and unhealthy aspects of Canadian multiculturalism (the systemic approach).

We have succeeded in developing a frame of reference for use in developing original treatment protocols that are able to meet the specific needs of African-Canadians. We have led this process in a style largely inspired by African traditions.

However, in hindsight, it became clear that in 2004 and 2005, the Steering Committee and particularly the Program Committee invested a great deal of energy in mobilizing sympathizers and neutralizing the forces that were trying to block or derail the project.

During the Think Tank discussions, some suggested that there was a seeming self-paralysis apparent that might be one of the delayed manifestations of the effects of slavery and colonization and that, as African-Canadians, we might be the perpetrators/victims of a state of apathy and a process of implosion (F. Fanon) that was making us turn our distrust and violence inward against ourselves.

This was seen by some as a failure to reach the objectives imposed upon ourselves and to produce a concrete model according to the accepted western canon.

Our committee is of the opinion that it did not succeed in creating a climate of creative and empowering co-operation, and that this was particularly true during the Think Tank sessions. This lack of cohesion has greatly contributed to the failure of reaching the three objectives.

On balance, however, we feel that the initial work begun by this process has planted a seed that future tending will bring to germination. From an African perspective, the importance of “process,” as opposed to “performance,” should not and cannot be underestimated. And, in fact, the “process” has been set in motion and will gain a natural momentum of its own in fulfilling what the process set out to achieve.

Some Avenues and Issues for Future Action

- Making full use of the potential of telecommunications, the mobilization of individuals, and the creation of networks of persons genuinely interested in furthering the project.

- A reassessment of the eligibility criteria for participation, particularly in light of the pressures that were brought to bear on the Program Committee on a number of occasions to exclude certain participants, on the basis of their skin colour.

- The expansion of, and periodic updates to, this report in keeping with its original spirit and intention.

- The establishment of a centre for clinical experimentation with the approach and the “model.”

- Discussion of the terms, conditions and timing of representations to the Kirby Report initiators on Canada’s mental health policies.

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Appendix I – Steering Committee

Since February 2004, the composition of the Steering Committee has changed considerably. Active members in the years 2004-2005 also included Sandra Carnegie-Douglas, Dominique Etienne, Carole Yawney, Deborah Barnes, et al.

The continuity since then has been assured, especially since 2005, primarily by:

- Antoine Dérose
- Trevor Wereley
- Clem Marshall
- Pascale C. Annoual
- Gilles Bibeau
- Carlo Sterlin

Appendix II – Advisory Committee

Name & Affiliation	Location
Akua Benjamin, School of Social Work, Ryerson University	Toronto
Akwatu Khenti, CAMH	Toronto
Amal Madibbo, OISE University of Toronto	Toronto
Antoine Dérose, Project Coordinator, CAMH	Toronto
Bagilishya Deogratias, Psychologist	Montreal
Carlo Sterlin, Hôpital Jean-Talon Transcultural Psychiatric Clinic	Montreal
Clem Marshall, MangaCom Inc. (Project Consultant)	Toronto
Dan Philip, Black Coalition of Quebec	Montreal
David Austin, Alfie Robert Institute	Montreal
Dawn P. Williams, Who's Who in Black Canada	Toronto
Deborah Barnes-Drummond, CAMH	Toronto
Dominique Etienne, CRRF	Toronto
Esme Hunt, Black Secretariat	Toronto
Fabienne Pierre-Jean, Communauté des Haïtiens de Montréal	Montreal
George-Marie Craan, APAMM (Rive sud)	Montreal
Gilles Bibeau, Université de Montréal	Montreal
Hazel Campayne, Ecumenical Network of Women of African Heritage	Toronto
Jean-Claude Icart, CRIEG (Centre de recherche sur l'immigration l'ethnicité et la citoyenneté),	Montreal
Karen Mock, Consultant	Toronto
Kaye Johnson, Annapolis Valley Human Rights Commission/Race Relations Officer	Halifax
Kwasi Kafele, CAMH	Toronto
Leith Hamilton, Côte-des-Neiges Black Community Association	Montreal
Marjorie Villefranche, Maison d'Haïti	Montreal
Pascale C. Annoual, Art therapist, Project Communication Officer	Montreal
Renee Ferguson, University of Toronto (youth rep)	Toronto
Robert Powell, Social Worker/Ph.D candidate	Montreal
Rosemary Sadlier, Ontario Black History Society	Toronto
Sandra Carnegie-Douglas, CRRF	Toronto
Shirlett Wint, Social Worker/Clinical Therapist	Montreal
Trevor Wereley, Committee Co-Chair, CAMH	Kingston
Wanda Thomas Bernard, Dalhousie University School of Social Work	Halifax

Appendix III –Some Recommendations Drawn From the Focus Groups

Excerpt from *Focus Groups Final Report: Halifax – Montreal - Toronto*

Participants generally commented on the fact that this process provided uncommon rehearsal space for opening up frank discussions on sensitive topics. Many were of the opinion that fearless conversations were significant tools in dealing more effectively with the mental health needs of populations of African ancestry across Canada.

1) **It is recommended that similar conversations, led by trained facilitators, be encouraged as instruments within modules for training providers of mental health services.**

   Some participants also indicated a need for training culturally and historically informed advocates to work with families, which would contribute to rebuilding urban communities.

2) **It is therefore recommended that the provision of culturally and historically competent advocates be integrated into mental health services for populations of African ancestry. It is further recommended that advocates accompany clients as requested during intake, treatment, rehabilitation and full reintegration/return to the larger community.**

   According to African-American social theorists Marimba Ani and Joy Leary as well in evidence provided by Louise Diop-Maes and Chief Kwabena Faheem Ashanti, populations of African ancestry remain the most incessantly assaulted and displaced, psychically as well as physically, across this globe and for the longest historical time (Ani, 1994; Diop-Maes, 2003; Leary, 2005).

3) **It is recommended that the role of colonizing languages be explicitly examined in terms of their impact on caring for the mental health of populations of African ancestry. It is also recommended that measures be put in place to eradicate or provide sanction of disrespectful behaviour or professional misconduct by caregivers with regards to people of African ascendance.**

   Several participants affirmed the primary role of language in supporting the healing process. For example, participants reported that Kreyol, Creole and Rastafari speech created a zone of emotional comfort that was critical in reinforcing their value as human beings.

   In speaking of language, we are interpreting it in the broadest terms to include songs/music and respectful speech as well as such language that encourages self-determination, while being mindful of the pitfalls of interpretation and translation.

4) **It is recommended that more time be appropriately allotted to initial contact of intake personnel with populations of African ancestry.**

   It is further recommended that languages of comfort (Kreyol, Ebonics and ancestral African languages) be more embedded in the initial evaluation process for all families and individuals receiving mental health services, since such evaluations, as some key informants pointed out, often set the stage for the regime of care prescribed.

   An argument might be made from the data collected that more time should be allotted to the initial stages of contact for persons of African ancestry. In terms of equity, this can be seen as an affirmative action measure.

5) **It is recommended that families be invited to bring samples of the music they usually hear to the attention of caregivers and to inform them of the person's customary food.** Participants on many occasions mentioned the centrality of music in their daily lives. Peoples of African ancestry have always lived in a rich soundscape (Conyers, 2001; Panassee, 1944; Bebey 1980; Reagon, 1992).

   In 'medicalized' spaces where they experience unaccustomed silences or discordant sounds those factors may become barriers to healing. Participants also mentioned the importance of traditional and comfort foods.

6) **It is further recommended that training for caregivers include ways of integrating the music that is familiar to clients into appropriate areas of their care.**

   Some experiences recounted showed that assets of populations of African ancestry are often ignored and sometimes even regarded as deficits during the treatment process. For example, caregivers usually ignore or dismiss religious or spiritual practices that are unfamiliar to them.

7) **It is recommended that a mandatory "assets inventory" be integrated into the intake process for populations of African ancestry.**

   Having to carry this out would at a minimum be a reminder to caregivers that religious rites or observances in Vodun/Vaudou, for those who practice them, are strengths and not liabilities in the healing process. The assets noted can then be integrated into the spectrum of tools for nurturing a more healthy personality. One participant within a focus group wondered aloud: "What therapeutic measures do we have in our DNA?"

8) **It is recommended that there be more in-depth training of professionals in confronting and responding appropriately to the common presence of embedded biases and stigma against populations of African ancestry.**

   Some informants and Focus Group participants noted that clinicians, from both inside and outside the umbrella of African ancestry, need tools that help them to confront contradictions in the way their own group/class/ethnicity/culture/race relates generally to people of African ancestry. Clinicians also need, it was suggested, space and time for deep reflection and self-interrogation to reshape and reframe some aspects of their practice. Some participants raised questions about the impact on healing when doctors, therapists or those filling other roles were predominantly members of other racial groups. Participants noted that those delivering care often expect expressions of collective African gratitude

Appendix IV – Eligibility Criteria to the Think Tank Session (Phase I)

- The total number of participants has been set at 40.

- In theory, anyone who has acquired knowledge and/or experience, either personally or "professionally," that could help us to reach our objectives for Phase I, as described in the Briefing Notes dated November 16, 2005, is eligible to participate in the Think Tank.

- Priority will be given to those who have elaborated preventative or treatment services that take into account the history, culture and political circumstances of African-Canadians.

- The following factors will not be determining factors:
  - mere interest in the issue
  - degrees or other evidence of academic training
  - being a descendant of African slaves.

- We will try to strike a balance between male and female participants, as well as between a wide range of age groups.

- We hope that at least two individuals who have personally received psychosocial, psychiatric and/or legal services will participate in the Think Tank.

Procedure:

- Individuals who believe that they meet these criteria will be asked to prepare a two-page description of what they can contribute to the Think Tank.

- As mandated by the Steering Committee, a three-person committee chaired by C. Sterlin will make the final decision with respect to acceptance or refusal to the Think Tank sessions.

Appendix V – Think Tank from September 27 – 29, 2006

Program and Ground Rules

Wednesday, September 27, 2006
EVENING

	Welcome to Val-Morin
6:00 p.m.	**Opening Session**
8:00 p.m.	Supper

Thursday, September 28, 2006
EVENING

5:30 p.m.	Break
6:30 p.m.	**Forum 6:** F. Fanon's Work; Relevance to Developing a New Model
8:00 p.m.	Supper

Thursday, September 28, 2006
MORNING

7:00 a.m.	Breakfast
8:30 a.m.	**Forum 1:** African Culture, Language, Philosophy and "Mental Health"
10:00 a.m.	Break
10:30 a.m.	**Forum 2:** Impact of History on Contemporary Forms of Identity

Friday, September 29, 2006
MORNING

7:00 a.m.	Breakfast
8:30 a.m.	**Forum 7:** Prevention: Strengthening Mental Defences of the Youth
10:15 a.m.	Break
10:45 a.m.	**Forum 8:** Traditional Therapies Vs. Modern Therapies: A New Model
12:15 p.m.	Lunch

AFTERNOON

12:00 p.m.	Lunch
1:30 p.m.	**Forum 3:** Transgenerational Trauma
3:00 p.m.	Break
3:30 p.m.	**Forum 4:** Canadian Multiculturalism and Services
4:30 p.m.	**Forum 5:** Inadequacy Of Services

AFTERNOON

1:30 p.m.	**Forum 9:** Structure And Functioning of a New Model of Adequate Services
3:30 p.m.	**Forum 10:** Perspectives for the Future: Agenda And Priorities
5:30 p.m.	**Closing** Light buffet

Guidelines for Working Together

1) Treat each other with respect and trust. We present our own ideas; show support for insights and experiences of other participants.

2) Strictly comply with decisions of the designated facilitators; lend our strengths and collaborate with their efforts in moving toward the goals outlined for this Think Tank.

3) Listen actively to the person who is speaking.

4) Seek to understand before expecting to be understood. Take responsibility to get clarification with designated persons if you don't understand something.

5) Allow for difference while establishing common ground. We welcome all voices as equal to our own.

6) Punctuality: Be on time to start and return on time after breaks.

7) Respect time limits by staying on task.

Appendix VI – List of Participants

EACRIMH: THINK TANK Val Morin, Quebec September 27-29, 2006		**Confirmed by:** **The Program Committee** **September 30, 2006**
Name & Affiliation	**Language**	**Place of origin**
Akua Benjamin, PhD., Ryerson University	Eng	Toronto
Antoine Dérose, Project Co-ordinator, CAMH	Eng/Fr	Toronto
Audley Coley, dancer, person with psychiatric patient experience	Eng	Montreal
Baba Koumaré, Dr., Psychiatrist	Fr/Eng	Mali
Billy Two Rivers, Mohawk Elder	Eng	Kahnawake
Carlo Sterlin, Dr., Hôpital Jean-Talon Transcultural Psychiatric Clinic	Fr/Eng	Montreal
Caroline Knowles, PhD., Sociology Professor		England
Cécile Rousseau, Dr., Ethnotherapist and Child Psychiatrist, Montreal Children's Hospital	Fr/ Eng	Montreal
Clem Marshall, MangaCom Inc., Project Consultant, Chair, Focus Group Committee	Eng/Fr	Toronto
Clement Grant, Emergency Orderly	Eng	Montreal
Dion Hodges, Drugs and Alcohol Prevention Worker	Eng	Halifax
Emil Kolompar, videographics	Eng	Toronto
Fatimah Jackson, MA, Youth rep	Eng	Toronto
Florise Boyard, Youth rep, MA intern, dramatherapy	Fr/Eng	Montreal
Frederick Hickling, Dr., Psychiatrist	Eng	Jamaica
George Rodriguez, percussionist	Fr	Montreal
Gilles Bibeau, PhD., Anthropologist, Université de Montréal	Fr/Eng	Montreal
Hirut Eyob, Youth Caucus Leader	Eng/Fr	Montreal
Jacques Newashish, cultural work with youth	Fr	Atikamekw nation

EACRIMH: THINK TANK Val Morin, Quebec September 27-29, 2006		**Confirmed by:** **The Program Committee** **September 30, 2006**
James Homiak, Specialist Rastafarian, Smithsonian Museum	Eng	Washington D.C.
Jaswant Guzder, Dr., Psychiatrist, Family and Adolescent Department, JGH	Eng	Montreal
Jean Pierre Muyard, Dr., Psychiatrist, Psychoanalyst and Homeopath	Fr	Paris, France
Joël Des Rosiers, Dr. Psychiatrist and author	Fr/Eng	Montreal
Joy Degury Leary, Ph.D., Social Worker and lecturer.	Eng	Oregon U.S.A.
Karlton Robinson, person with psychiatric patient experience	Eng/Fr	Montreal
Kaye Johnson, Race Relations, Cross Cultural Understanding & Human Rights (RCH) Coordinator	Eng/(Fr)	Halifax
Kwasi Kafele, Director of Diversity, CAMH	Eng	Toronto
Laënnec Hurbon, Ph.D., Anthropology, Professor	Fr	Haiti
Llewellyn Joseph, Dr., Psychiatrist	Eng	Toronto
Louise Adongo, MA, Youth rep	Eng	Halifax
Lucien Hounkpatin, Dr., Ethnotherapist, Director, Centre G. Dévereux, Paris	Fr	France
Miriam Rossi, Dr., Adolescent Medicine Practitioner	Eng/Ital	Toronto
Monique Dauphin, Elder, Community organizer and tradipractionner	Fr	Montreal
Nadine Mondestin, Youth Rep and Admin. support	Fr/Eng	Montreal
Pascale C. Annoual, MA., Art Therapist and Project Communication Officer	Fr/Eng	Montréal
Sandy Miller, MSW student, person with psychiatric patient experience	Eng	Halifax
Sushrut Jadhav, Dr., Psychiatrist, Director Nafisat Centre	Eng	London, UK
Waleed Abdoul Hamid Kush, drummer		Toronto
Wanda Bernard, Ph.D., Director School of Social Work, Dalhousie University	Eng	Halifax

EACRIMH: THINK TANK Val Morin, Quebec September 27-29, 2006		**Confirmed by:** **The Program Committee** **September 30, 2006**
Zab Maboungou, Ph.D., choreographer, Professor of Philosophy	Fr/Eng	Montreal
Zakaria Rhani, PhD candidate, ethnologist, Moroccan healing traditions specialist	Fr	Morocco/Montreal

Appendix VII

Objective I: To demonstrate deficiencies in the psychiatric and psychosocial services currently available to African-Canadians.

Patrick Cloos, MD, MSc, PhD (Candidate)
January 2007

I. The Context: Blacks[18] in Canada

African-Canadians: A Large Demographic Group

In *2001 Community Profiles*,[19] Statistics Canada (2002) identifies twelve *visible minority* groups, including the *black* population.[20] According to 2001 Census data, *blacks* make up the third largest *visible minority* in Canada (representing 2.2%[21] of the total population), the largest in Montreal (4.1%), the second largest in Halifax (3.7%); and the third largest in Toronto (6.7%).

In 2001, 47% of *blacks* lived in Toronto, while 21% were in Montreal. Milan & Tran (2004) pointed out that in Canada, for the 1991-2001 period, the *black* population increased 31%, as opposed to 10% for the rest of the Canadian population, and 58% for total *visible minorities*; furthermore, in 2001, 45% of *African-Canadians* were born in Canada, and 10% of *blacks* were third-generation Canadians. Among *black* persons born outside of Canada, most come from the Caribbean. In 2001 in Quebec, of the 152,195 people who identified themselves as *black*;[22] over half (59.1%) stated that they were born outside of Canada.[23]

Milan & Tran (2004) also noted the group identified as *African-Canadian* is comparatively younger than the overall Canadian population: 30% are under 15 years of age and 17% are between 15 and 24, as opposed to 19% and 13%, respectively, for the total Canadian population.

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[18] The term *blacks* refers to social identity (Appiah, 1996). In this work, the concept of *black* (as well as of *white,* even *Asian)* refers to people who are socially identified or identify themselves as such. The terms *African-Canadian* and *African-American* refer to blacks living in Canada and in the United States respectively. These terms are italicized to underscore the nebulous nature of the concept and the accompanying racial connotations. Generally speaking, *race* or *ethnic group* is recorded differently among federal and provincial institutions in Canada*.* At the federal level, Statistics Canada does record Canadian populations by *racel ethnicity*. In provincial data bases, on the other hand, it is difficult to obtain a clear picture of the proportion of *visible minorities*, particularly of *blacks*, in the corrections system and in youth centres, as well as their health status compared with the rest of the Canadian population; for example, no information on health status as a function of *racel ethnicity* is published on the *Quebec Health and Social Services Agency* website..

[19] Statistics Canada. 2002. 2001 Community Profiles. <http://www12.statcan.ca/english/Profil01/CP01/Index.cfm?Lang=F>

[20] According to Statistics Canada, *as defined in the Employment Equity Act (1986), members of visible minorities are persons (other than Native Peoples) who do not belong to the Caucasian or white race.* Source: <http://www.statcan.ca/francais/freepub/82-221-XIF/01103/defin4_f.htm#85>

[21] This percentage corresponds to 662,000 individuals; the *black* population could reach 1,000,000 individuals within 10 years. Source : <http://www.statcan.ca/Daily/Francais/050322/q050322b.htm>

[22] In Quebec in 2001, 91.5% of the *black* population was living in the greater Montreal census area. Source : <http://www.micc.gouv.qc.ca/fr/recherches-statistiques/stats-recensement.html>

[23] In 2001, Haiti was the home country of 47,845 people among the Quebec immigration population. An immigrant is defined here as a person born or whose parents were born outside of Canada. Source : <http://www.micc.gouv.qc.ca/fr/recherches-statistiques/stats-recensement.html>

African-Canadians: A Socio-economically Disadvantaged Group

Despite their numbers, several indicators suggest that in Canada, many *blacks* are especially disadvantaged socio-economically. In 2001, 46% of *black* children were living in single-parent homes and 44% were in low-income households, as opposed to 18% and 19%, respectively, of the total Canadian population (Milan & Tran, 2004). According to *Ligue des Noirs* figures (1996), unemployment rates were higher among *blacks* than among the other ethnic groups in Quebec, despite high rates of schooling. This finding is consistent with data from the Quebec Ministry of Immigration and Cultural Communities (2005), which indicate that, according to Statistics Canada 2001 census figures, *blacks* experience a higher rate of unemployment and have lower average incomes than the total Quebec population (respectively, 17.1% as opposed to 8.2% and $19,451 as opposed to $27,125). Milan & Tran (2004) also observed that, in 2001, despite *blacks* born in Canada attaining comparable education levels to their Canadian-born counterparts, their employment rate was lower (76% versus 81%), unemployment was higher (7.9% versus 6%) and the average employment income was approximately 20% lower than their Canadian-born counterparts. The same authors also found that although the unemployment rates of Canadian-born *blacks* have improved since 1991, they have not received the salary increases recorded for their Canadian-born counterparts. Even worse, *blacks* born abroad suffered recorded a diminution in salaries of 5% for the 1991-2001 period, compared to a diminution of 1% for all foreign-born Canadians.

II. The Public Services' Response to Cultural Diversity: An Issue of "Best Fit" for Better Integration and Better Health

Beaulieu (1987) observed that in Quebec, interventions among the different *ethnic* groups demand substantial resources and require special training for service providers to respond appropriately to this demand. According to Bourque et al. (1997), every year tens of thousands of new immigrants settle in Montreal:[24] the cultural diversity of this client group renders the Quebec populations' needs even more diverse; this situation represents a mammoth challenge for the receiving society's agencies that must be addressed to keep faith with principles of equity and the individual's right to a society's public services. Dealing with this increasing demand should be a high priority, therefore, in order to foster the integration of all Quebec citizens, and avoid contributing to their exclusion and subsequent marginalization. In fact, research done among groups that use Quebec's youth centres confirms that, at least in part, the risk of youths getting caught up in street gangs can be linked to a lack of contact with public services, besides other factors such as immigration and poverty (Hamel et al., 1998). Perreault & Bibeau (2003), for instance, observed that some young people turn to gang membership in the hope of resolving such problems as social exclusion.

Recognizing that in a multi-ethnic area such as Montreal, a "best fit" in services refers to their ability to adjust to the demand, that is, the client group's specific characteristics and needs, Désy et al. (2005) list several factors that make access to such services more difficult for immigrants, and intervention more complex, not to mention more costly.[25] Among these factors the authors cite language, cultural differences between source providers and beneficiaries (for example, religious beliefs, values, customs), ignorance of the services available (lack of information, misperception of the role of service providers, mistrust regarding the services), and factors relating to immigration itself and the new environment (uncertain socio-economic situation, conflicts within the family, racist experiences). We are therefore forced to conclude that there is a tendency for services to be designed to fit the requirements of public institutions. However, what about the views of the individuals and communities these services are supposed to serve? Few studies have looked into the specific needs of the *African-Canadian* community,

[24] In 2001, the proportion of immigrante within the Canadian population was 18.4% and, in Quebec, 10%; 13% of Canadian immigrants were living in Quebec. Source : <http://www.micc.gouv.qc.ca/fr/recherches-statistiques/stats-recensement.html>

[25] Désy et al. (2005) estimate that for the Montreal-area youth centres, the additional annual cost of providing immigrant-specific interventions amounted to around $10,000,000.

despite its being, as we have seen, a substantial community in Canada as well as in the province of Quebec.

Racism: A Barrier to Social Integration With Deleterious Implications for Health

Unlike in the United States, the issue of institutional discrimination against minorities is still largely unexplored, although the situation has changed somewhat, especially since the 1992 establishment of a commission of enquiry into racism in the Ontario judicial system (Wortley, 1996). In Montreal, the Quebec Health and Social Services Ministry and the Family and Youth Ministry (1999) acknowledged that *ethnicracial* identification does restrict access to housing and employment. Cognet (2002) also found racism to be present in Montreal's health services both within daily practice (patient-doctor relationships) and amongst health professionals as a group (limited access to certain positions). This tendency was confirmed by Drudi (1997), who noted that *blacks*, particularly in Quebec, were not only discriminated against in the labour market, despite their work-related skills, but also continue to encounter discrimination as professionals. Kaspar and Noh, while acknowledging that perceptions of discrimination vary from group to group, nevertheless pointed out that *Canadian blacks have been the most frequent targets of discrimination and unequal treatment, and generally experienced them in their most direct and open forms*.[26] In the course of an investigation into Quebec's Haitian community, Clarkson and Eustache (1997) observed not only the disdain clinicians exhibited towards Haitians' speech patterns but overt racism toward this community.

BC Partners for Mental Health and Addiction Information[27] confirmed that racism is a daily fact of life for visible minorities and that this phenomenon has direct consequences for mental health. Similarly, several authors note the harmful effects of racial discrimination on health in general (Kaspar and Noh, 2001; Krieger, 2000; 2003; Spitzer, 2005; U.S. Department of Health and Human Services, 2001); racism is deemed a chronic stressor (Public Health Agency of Canada, 2002; Kaspar and Noh, 2001; Spitzer, 2005) that affects health – directly or indirectly – particularly through the phenomenon of social exclusion, which restricts access to goods and services (Public Health Agency of Canada, 2002; Jones, 2001; Spitzer, 2005; WHO, 2003).

African-Canadian Integration and Health: A Priority for Quebec?

Le *Rapport du Groupe de travail sur la pleine participation à la société québécoise des communautés noires* (2006) [The Task Force Report on Full Participation in Quebec Society by Black Communities] recently recommended a policy to combat racism; improve employment access by people from visible minorities and ensure better representation of such persons in positions of responsibility in public service, education and elected office; and offer enhanced support to families and youth. Problems such as young *blacks* dropping out of school and their over-representation in the judicial system have been identified and recommendations made *to improve the image of blacks in society,* as well as to develop models that increase the numbers of *blacks* graduating from school. The report also recommends that English-speaking Quebecers should be given better information about the social and health services available in English. Although Quebec's political classes may now be aware of the importance of putting strategies in place to promote the social integration of *blacks*, we must point out that neither Quebec's association of CLSCs and CHSLDs nor the Health and Social Services Ministry (2004) in their reports identified any specific measures in mental health services to address the requirements and concerns of the *black* population.

[26] Kaspar and Noh, 2001, p.11

[27] The Primer – May 2003, www.heretohelp.bc.ca

Black Mental Health and Health Services

The central Montreal Public Health Branch (2001) mentioned the inverse relationship between poverty level and health status, which is also true in the case of mental disorders.

In the United States, the precarious situation in which many *African-Americans* find themselves (homeless, in jail, poor), sets up a barrier blocking access to mental health services; furthermore, this situation likely plunges many *African-Americans* into the hospital admission-discharge-readmission cycle (Snowden, 2001). In fact, not only are *blacks* over-represented in psychiatric institutions, they are also most often incarcerated involuntarily (Lindsey et al., 1989). Snowden (2001) added that *African-Americans* exhibit a higher probability than other racial groups of dropping out of mental health programmes, receiving emergency-level care and undergoing treatment that is non-voluntary or which involves the legal system.

As we saw earlier, the socio-economic situation of many *African-Canadians* appears to be hazardous to their future well-being. There are some indications that *blacks* are over-represented in some non-voluntary facilities in Quebec: 6.5% of patients committed (in institutional custody) and 27.2% of patients placed under public curatorship by Quebec's "Tribunal administratif" were identified as *blacks*.[28] Furthermore, Jarvis et al. (2005), looking into emergency admissions in a Montreal hospital, found that *African-Canadian* patients admitted for psychoses are more often than other patients sent by the police or arrive by ambulance. The authors note that, although the reasons for this finding are unclear, it could be due to barriers blocking access to psychiatric facilities, a situation which could drive *African-Canadian* patients to delay turning to mental health services for help. This conjecture was corroborated by *BC Partners for Mental Health and Addiction Information* who contend that mental health services are not culturally suited to *visible minorities*.[29] Indeed, Whitley et al. (2006), observing a disparity in the use of mental health services between immigrants and persons born in Canada, explored the reasons why immigrants from the English-speaking Caribbean living in Montreal were reluctant to use the services. It turned out that these people's attitudes toward mental health services are shaped by their experiences with health-care services in general. They seem reluctant to use services that do not meet their needs: they have the perception that these services are geared toward "medicalizing" the problem rather than the quality of the doctor-patient interaction (interviews too brief; physician's hostile attitude; scant emphasis on understanding the problem; little time allotted for patient's questions).

Youth Protection Services

While the recording of information on the ethnic origin of Quebec youth centre users is as yet not systematic,[30] Drudi (1997) mentions that in 1996, among the 826 users of the Montreal Youth Centres (CJM) who were born outside Canada and who identified their home country, 378 came from Haiti, which puts them way ahead of other users born outside of Canada. According to the author, discrimination against *blacks* could account for their over-representation in rehabilitation centres.

Bernard (2001) also points out that young *blacks* are over-represented in the youth protection system. His conclusions are that proportionately more young Haitians were being reported to the youth protection system than their Quebec peers,[31] and the Haitian cases reported and accepted were more frequently

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[28] This information comes from the psychiatric unit of a hospital in the Côte-des-Neiges/Notre-Dame-de-Grâce borough, where 13.3% of Quebec's *black* population are estimated to reside (about 15,000 individuals). Source: Statistics Canada—2001 Census); the *black* population represents about 11% of the borough's total population of 171,395 (Source: site Internet ville.montreal.qc.ca). These numbers show trends for the years 2003 to 2006 inclusively and were obtained from lists of patient under non-voluntary custody and patients referred by the *Tribunal administratif du Québec*. Patients were identified as *black* by a member of the administration and the medical staff of the psychiatric unit (January 2007).

[29] The Primer, May 2003, www.heretohelp.bc.ca

[30] It appears, however, that efforts in this direction are scheduled to start in 2007.

[31] The reporting of young Haitians is more often undertaken by social workers and teachers, as opposed to young Quebecers, who are more often reported by a family member (Bernard, 2001). It should be mentioned, however, that a pilot project is underway in Montreal to prevent reporting of young *blacks;* in addition, the Batshaw Centres are working with the Black Community Resource Centre to improve services (Batshaw Youth and Family Centres 2005–2006 annual report).

considered *urgent* (22% for young Haitians versus 15.8% for Quebecers); furthermore, young Haitians were more often subject to placement than young Quebecers (65% against 50%) and less often kept within their family (35% versus 50% for Quebecers). In addition, cases of young Haitians that were rejected were more often referred to different social services than were Quebecers, and recourse to the courts for young Haitians in the youth protection system was more common than for their Quebec counterparts (68% versus 52%).

On the basis of the Désy et al. findings (2005), we would estimate that roughly 25% of the youth centres and the Batshaw clientele, whose ethnic origin was reported, were *African-Canadians*;[32] as opposed to the Montreal centres, where about 30% of the parents of these youths born outside Canada, were born in Africa or in the Caribbean region.[33]

Bernard (2001) is of the opinion that the social (single-parent household) and economic (poverty) predicament of many young Haitians often disqualifies them from the (volunteer) family support services that the youth protection system could assign them. In their investigation of the Montreal area's youth centres, Désy et al. (2005) states that the type of interactions between the service providers and the immigrant families influences service-provider decisions about the immigrant families, for instance, whether they apply voluntary measures or not; furthermore, it appears that a significant proportion of workers (41.1% in the Montreal youth centres versus 30.8% in Batshaw) consider *their evaluation tools as unsuitable for their immigrant clientele*. [34]

Justice and Crime

Canadian legal statistics are not produced to reflect *race/ ethnicity* dimensions, as can been seen from the *Juristat* website.[35] Roberts and Doob (1997) reported that such socio-demographic information is not always available from provincial prison systems.[36] The Ontario corrections system, for example, collects data on prisoners' ethnic origin, but the information is not always published. In other provinces, as is the case for Quebec, corrections data are recorded for the categories of "Native," "Non-Native," "French-speaking" and "English-speaking." Bernard (2001) noted that studies of the Quebec justice system investigating differential treatment based on *race/ethnicity* are few and far between.

Nevertheless, following a survey conducted in 1994 among members of Toronto's *Asian, black* and w*hite* communities, Worthing (1996) indicated that *African-Canadians* view themselves as being the target of more discrimination by the justice system than the other groups do, and this perception of injustice can be correlated with the number of contacts they have had with the police and the courts.

Roberts and Doob (1997) point out that *blacks* are over-represented in the Canadian corrections system;[37] due, at least in part, to discriminatory treatment at various stages in judicial procedures.[38] In 1994, *blacks* comprised 5% of the federal prison population, while at the time representing only 2% of

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[32] 332 out of a total of 1,335. This number is arrived at by adding the categories of Other African (8), Other West Indian (2), Other Caribbean (10), Other Black (15), Haitian (1), Jamaican (26), Black African (4), Black American (65), Black West Indian (105), Black Canadian (96). See Désy et al. (2005), annex 3, p. 38.

[33] 531 out of 1583 parents of young Montreal youth centre clients were born in Haiti (458), Central Africa (46), West Africa (12), Somalia (7), Nigeria (3), West Indies (2), Ghana (2), and southern Africa (1). Note that this proportion underestimates the proportion of *blacks*, since it does not take into account parents born, for example, in Europe, Central America, or even in South America (Désy et al., annex 3, p.39).

[34] Désy et al., p.26, 2005

[35] Statistics Canada's website address for *Juristat*: http://dsp-psd.pwgsc.gc.ca/dsp-psd/Pilot/Statcan/85-002-XIF/85-002-XIF.html

[36] Roberts and Doob (1997) note that discussions revolved around the dangers inherent in this type of information of stigmatizing the individuals concerned due to their racial identity. Furthermore, the authors stress the broad mix there is among *black* immigrants to Canada, particularly between English- and French-speakers or those whose origins can be traced to the Caribbean and to Africa.

[37] The authors mention that this disproportion does vary among the different facilities.

[38] The authors believe that it is on contact with the police that discrimination looms largest, as the longer temporary detention terms being handed down to *blacks* would suggest. Citing the report of the *Commission on Systemic Racism in the Ontario Criminal Justice System,* Roberts and Doob also emphasize the prevalence of racism in Ontario's prisons.

Canada's population.[39] Figures from admissions to the Ontario prison system reveal that in the early 1990s, the incidence of *black* male admissions was five times greater than for their *white* counterparts, and a little fewer than twice the number of *aboriginals* (Roberts and Doob, 1997).

III. Conclusion

Our work has led us to a number of conclusions, starting with the demographic significance of the black population in Canada and in Quebec. In addition, a number of socio-economic indicators demonstrate that a significant proportion of the *African-Canadian* community has been subject to the corrosive effects of discrimination, which have, according to current understanding, both direct and indirect malignant effects on health, particularly mental health.

Information available also suggests that Canada's *blacks* are over-represented in non-voluntary facilities—youth protection centres and prisons—a situation that could indeed result from discrimination. From the psychiatric statistics, data from the United States are very clear: *African-Americans* are far and away the largest group found in psychiatric institutions, in which they are often placed involuntarily. According to our data, *African-Canadians* also appear in disproportionately large numbers in some psychiatric facilities. Finally, several authors point out that there are cultural factors inhibiting interactions between service providers and clients in these facilities and that these factors contribute to their "poor fit"—deficiencies in the system that also arise out of the problematic socio-economic situation in which a significant proportion of the *African-Canadian* community finds itself.

[39] Persons with a sentence of less than two years are incarcerated in provincial prisons, and for sentences over two years, in federal penitentiaries (Roberts and Doob, 1997).

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Excerpts from Historical Context: The Legacy of Racism in Canada[40]

(...) The enslavement of Africans, racial segregation and discrimination are also part of Canada's history. Black slavery was actively practiced in Canada. Between 1628 and the early 1800s, approximately 3000 people of African origin came to Canada and most were held as slaves. In 1793, the Parliament of Upper Canada (now Ontario) under Lieutenant Governor John Graves Simcoe passed an *An Act to prevent the further introduction of Slaves, and to limit the term of contracts for Servitude within this Province, the first act to limit slavery in the British Empire. Ontario became a destination for those fleeing slavery in the United States via the "underground railroad." In 1833 the British Parliament's Emancipation Act* abolished slavery in all parts of the Empire, including Ontario, but its legacy remained. Prejudice and discrimination would still constrict the opportunities of most Canadians of African ancestry.

African Canadians were excluded from schools, churches, restaurants, hospitals and public transportation. They were restricted to menial, low-paying and exhausting labour. Many African Canadians lived in segregated communities in Nova Scotia, New Brunswick and Ontario. In addition, residential segregation was perpetuated through racially restrictive covenants attached to deeds and leases. The Ontario legislature established segregated schools, and legal challenges to these failed. The legislation remained on books as late as 1964.

Prior to human rights statutes, court challenges to address racial discrimination were largely unsuccessful. In 1939, the Supreme Court of Canada rejected a lawsuit for humiliation brought by Fred Christie, a Black man who was refused service by a Montreal tavern. The Court declined to comment on the racial discrimination, instead concluding that freedom of commerce allowed a merchant to deal with the public in any way he may choose.

[40] Ontario Human Rights Commission, http://www.ohrc.on.ca/english/publications/racism-and-racial-discrimination-policy_1.shtml#_ednref8

Appendix VIII

What are the existing instruments of prevention that might potentially be employed in confronting psychological and social consequences of intergenerational trauma, legacies of enslavement and colonization?

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There is a simple link between a mother of colour who is anxiously awaiting the birth of her child in an African-Caribbean community held ransom by racism and a Black teenager whose only rites of passage are street life or, more often than not, street gangs. . . I'm alluding to this simple link: a medico-social institution with proper intake facilities for the children from both of those at-risk communities does not exist. . . .

Individuals in political exile and immigrants from countries that are/were colonized as well as countries marked by genocide or enslavement set foot on Canadian soil within the context of "survival" in a material sense (i.e. dealing with poverty . . . living on the edge) or as "citizens" (excluding those who are from political minorities within authoritarian regimes where freedom is crushed). They exist within a state of constant anxiety about security, their anxieties exacerbated in turn by linguistic or economic barriers. In addition, they often feel cut off from any opportunity to reconnect with their ancestral culture, which can provide a frame inside which the way they express their humanity can be understood, where one can also begin to understand how the crises that beset their path shape their fate and where it is possible to make sense of how they come to terms with life and death.

For, once they arrive, they are often obliged to adapt to another system (symbolically Western), which seems to represent opulence, democracy and a level playing field . . . and yet remains inaccessible, hard to understand and is therefore experienced as hostile.

How does one overcome the restrictions of the present system and set up a reception structure that calculates the costs of historical wounds that are both individual and collective, measures them in the currency of mental health and also integrates the cultural and religious values of these populations that may have lost their bearings insofar as their control over their daily lives is concerned?

The quality of the reception that their environment provides will, by and large, be the determinant as far the mental health of children in these communities is concerned and that should therefore be the stage at which intervention in the form of preventive measures should take place.

RECEIVING THE NEWBORN CHILD: AT THE CROSSROADS OF TRANSGENERATIONAL HISTORY AND THE COMING INTO BEING OF A NEW LIFE

All the recognized clinical works on early childhood have established the fact that the circumstances under which children come into the world and the conditions that govern their earliest years are critical factors in shaping these new beings as they begin the process of becoming a "young human," totally helpless and completely dependent on their environment. This natural and specifically human conditionality (other species of animals attain their independence at a more rapid pace) demands the establishment of a climate that is made as materially and emotionally secure as a baby's needs dictate in order for it to survive. However, the environment in which the pregnancy takes place as well as the psycho-emotional condition of the future mother can aggravate the state of insecurity that is the "natural" condition of the human species.

With reference to Caribbean and African mothers, they do not only bear the burden of adapting to a new country but, in addition, they carry the scars of both their individual and transgenerational histories as

markers of traumatic events that occurred in the lives of their exploited, abused and humiliated ancestors . . . who were treated like things while suffering enslavement.

That memory . . . those memories are always present and, more often than not, are unconsciously passed on with each new birth . . . While the onset of pregnancy itself gets the cycle of new life going it also activates the factors that place that life at risk.

That is why, in order to have a way of assessing the eventual impact of such traumas within the emotional history of future mothers, tools must be refined for them to take inventory of the traumas their family suffered over the three or four preceding generations. These tools which can be used in preparing expectant mothers for childbirth are designed to prevent them from projecting their own anguish, an anguish born of past suffering, onto their unborn child.

PROPOSAL 1

Organize discussion groups every two weeks starting at the fifth month of pregnancy and continuing until the baby arrives. Under this proposal, every mother-to-be will be asked to set up her own family tree going back at least three generations and then to list on it all the traumatic events she can remember. As a follow-up to this exercise they are encouraged to consult and interview any grandparents still alive and collect their stories of their own traumas. The objective of that particular activity exercise is to unpack any secrets that have been buried under feelings of shame, internalized anger or social taboos.

It is expected that such individual accounts will be used in conjunction with storytelling and role-play as a way of bringing the experiences of ancestors under enslavement and colonization to life through words, music and movement. . . . Re-creating traumatic past events under the guidance of a psychologist or therapist is already an accepted strategy for lifting scabs and releasing the power of buried memories.

The bottom line is this. To the extent that that is possible, we must prevent the site into which the child will be born from being a place that is haunted by the ghosts of those who suffered tragic fates in the past.

Translated from French by Clem Marshall, 11-02-07

Appendix IX – Summary: Testing the Clinical Efficacy of Cultural Formulations in a Psychiatric Intensive Care Unit

Principal Investigator: Sushrut Jadhav, University College London
Start date: March 2006 for a duration of 18 months
Funded by the Department of Health.
Study site: Mornington Psychiatric Intensive Care Unit, St Pancras Hospital, London, England

UK Department of Health publications, numerous independent enquiries, and research in the field of British Forensic Mental Health have consistently recommended equality of access, experience and outcome for Black and Ethnic Minority mental health service users. Black and Ethnic Minority communities perceive forensic services as culturally insensitive, discriminatory and disempowering. It is also evident that culture is consistently viewed by health professionals as synonymous with ethnic minority, excluding themselves and indigenous white Britons. Bold innovative interventions that are culturally appropriate, evidence based, effective, and value for money are needed. Such an approach also requires the notion of culture to be expanded to include the culture of mental health professionals, management, and hospitals; rather than a singular focus on ethnicity of patients.

The lead applicant has developed a unique method, based on existing theory in medical anthropology, and grounding the DSM-IV Cultural Formulation approach within an inner London setting. This approach provides users with an opportunity to systematically narrate their suffering in terms of their own cultural vocabulary. Each narrative is transcribed, structured and circulated to all members of the multi-disciplinary mental health team, and to the user. A brief questionnaire to the clinical team collates responses on how this additional narrative might change their understanding of the user's suffering. Responses to this are then deployed to effect concrete changes in treatment plans. Pilot interviews conducted in a locked adult psychiatric intensive care unit, with 20 patients from different ethnic backgrounds, have consistently revealed clinically significant new information about patient's lives, improved rapport, and allowed crucial changes in treatment plans and diagnosis. This pilot study also revealed functional and structural barriers to delivering culturally sensitive care, and identified stereotypes about culture, held by both staff and management.

The proposed dual ethnographic and quantitative research aims at a systematic and rigorous evaluation of the clinical efficacy of the Cultural Formulation approach, in a secure adult male psychiatric intensive care unit. Two social scientists (Dr. Samrat Sengupta and Ms. Jenny Bloomfield) with mental health background will conduct a randomised clinical intervention trial. This trail will test the efficacy of the CF interventions with 35 male patients, regardless of ethnicity, admitted to this acute adult psychiatric unit, and compare with 35 controls. Demonstrating the efficacy of this unique intervention will include robust outcome variables encompassing both patient experience and professional concerns. Simultaneously, a year long clinical ethnography of the unit will both complement and systematically document concrete institutional and functional processes that impede or enhance delivery of culturally sensitive care, including ideas of how culture is constructed in acute psychiatry. If successful, this approach offers potential for mainstreaming within routine clinical care in both forensic and acute mental health settings.

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Academic: http://www.ucl.ac.uk/medicine/behavioural-social/principal-investigators/sj.html
Journal: http://www.tandf.co.uk/journals/carfax/13648470.html

Appendix X - The European-American Psychosis: A Psychohistoriographic Analysis Of Contemporary Western Civilization

Frederick W. Hickling

The present war in Iraq and the fighting and instability in the Middle East have posed significant challenges in the conventional comprehension of lunacy and are of major concern to psychiatry (1-3). The enormous cost of this pugilism has resulted in profound psychological and political challenges in the U.S.A. that reverberate around the world (4). Simultaneously, the development of multicultural societies in North America and Europe following the dissolution of European Empires has resulted in major challenges in the understanding and delivery of psychiatric services (5,6). These worldwide psychiatric challenges are often viewed through first world spectacles, which ignore the perceptions of the rest of the world, and often sidelined as *transcultural psychiatry.* This examines the perception that the five hundred year-old Western civilization that has dominated the rest of the world has been based on a delusional formation.

This analysis is made from the ethnographic and dialectic perspectives of historical experiences using the technique of *psychohistoriography*, a large group analytic technique developed in the Bellevue Mental Hospital, Jamaica in 1978, and derived from thirteen group ethnographic experiences in the Caribbean, the U.S.A., Canada and the U.K. between 1978 and 2006. The psychohistoriographic analysis has identified a number of watershed lines of history that represent perceptions of European and American experiences that are challenged by the dialectical antipodal perceptions of non-Europeans around the world. Transposing these theme-line cadences into the contemporary conceptual definition of the delusion results in antipodal formulations that challenge the conventional white European perceptions of history, and provide multicultural insights suggesting a collective world of *delusions and delusional encapsulations,* which have shaped contemporary life. These include *the delusion of discovery vs. the reality of invaders; the delusion of ethnic cleansing vs. the reality of genocidal mass murderers; slavery—the ultimate delusion vs. forced migration and non-personhood,* and *the delusion of terrorism vs. the intefadah of insurgent freedom fighters* (see Fig. 1:The European-American Delusion).

The major insight emerging from the psychohistoriographic analysis is the concept of the *European-American psychosis* (see Fig. 1: The European-American Psychosis) as the major developmental imperative of the past five hundred years of Western civilization that leaves the world skewered by the ongoing lunacy of war. This analysis indicates that people of colour will always be subjected to racist oppression from the European-American civilization until the European delusion is defeated and encapsulated.

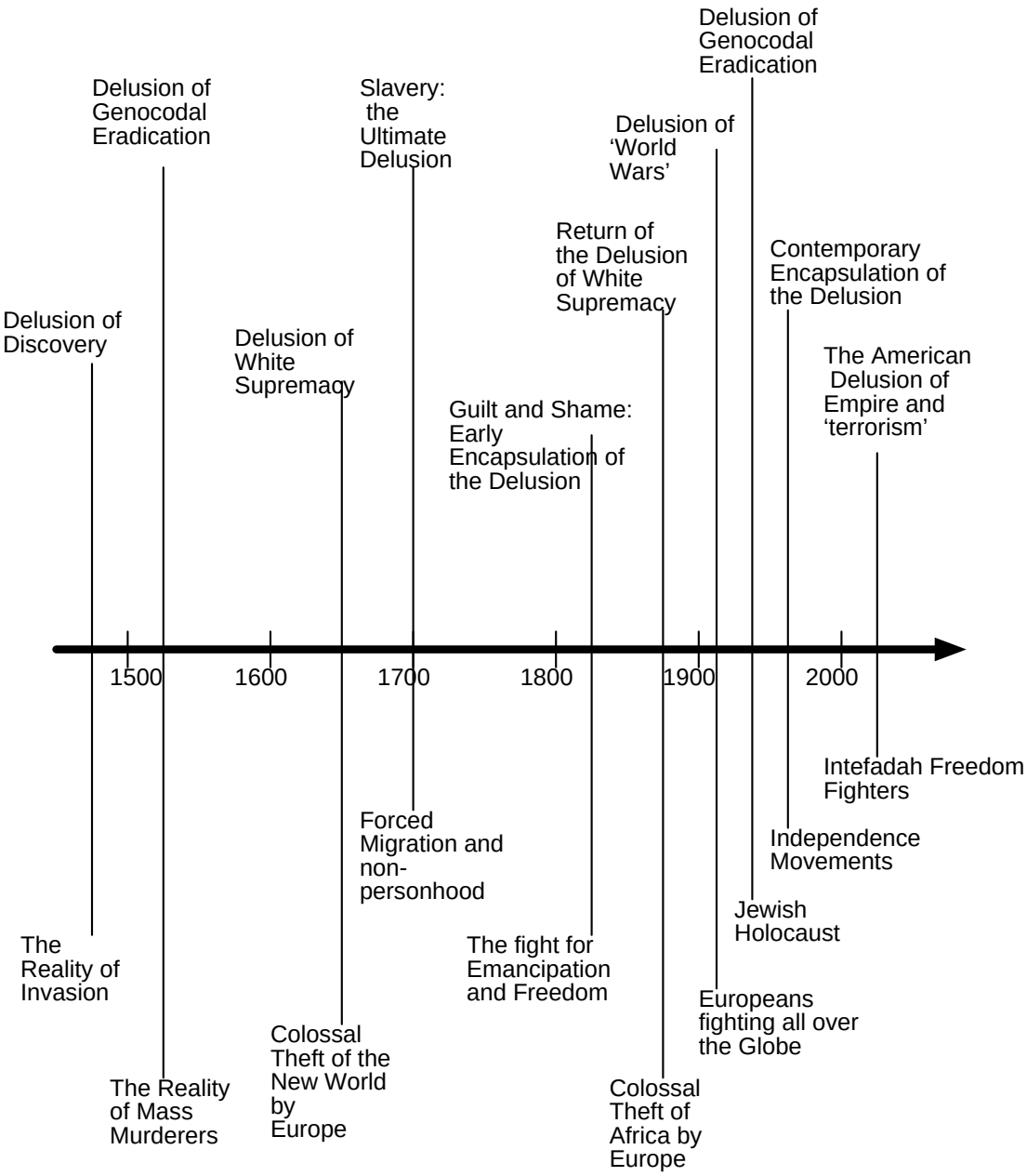
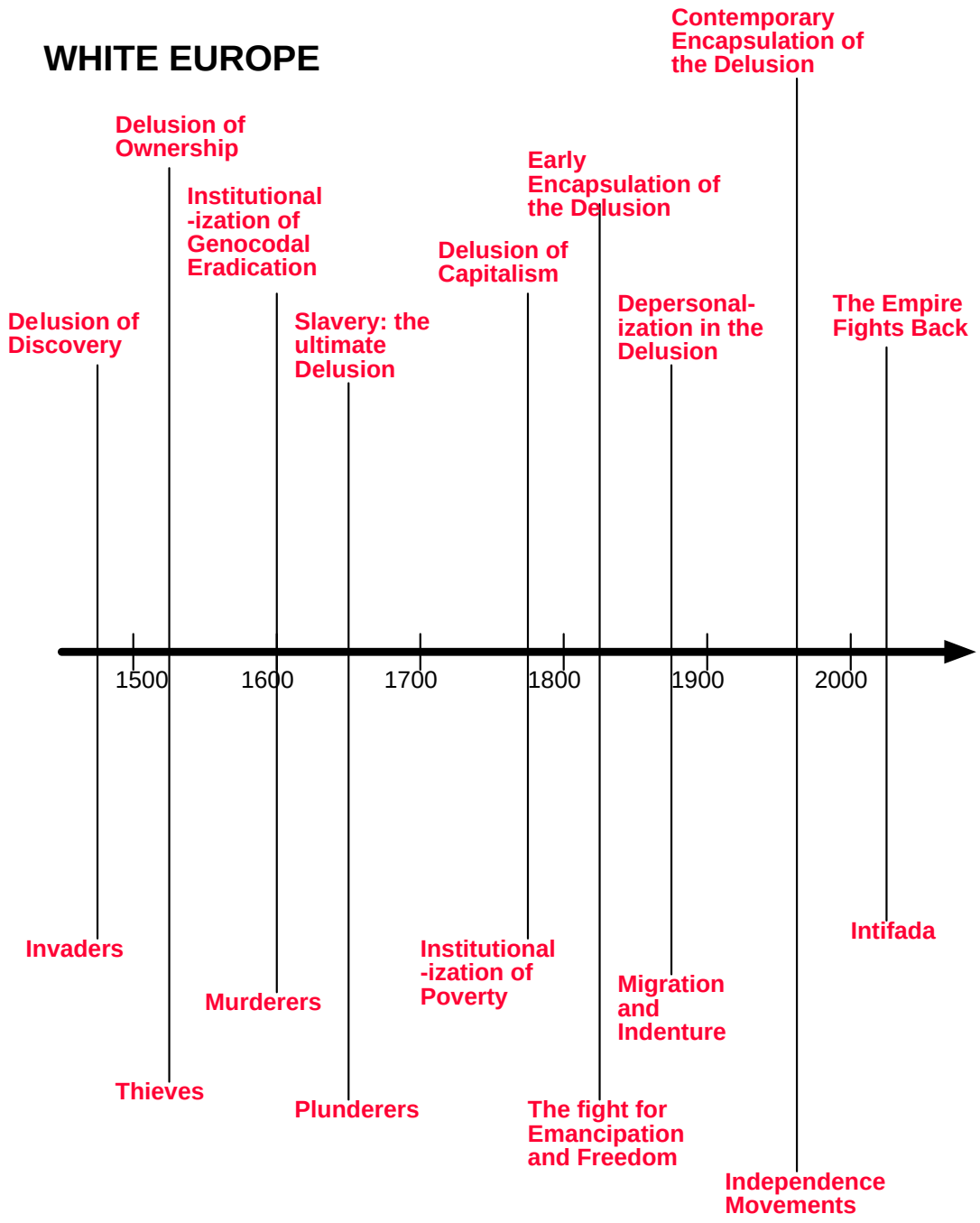


Fig. 1. Psychohistoriogram: The European-American Psychosis



Psychohistoriogram The European-American Delusion