Path to Empowerment: African Nova Scotian Strategies to Navigate the Intersection of Race and (dis)Ability

Wanda Elaine Thomas Bernard

Kimberly Berry   **Rajean Willis**

Abstract

Descriptions of intersectionality frequently rely on images of roads and intersections to represent how multiple systems of oppression converge. In these metaphors, roads represent the route by which negative forces of exploitation and oppression travel and interact. Roads and paths can also be used to represent an egress route taken to escape harm and move toward something better. This paper presents the voices of African Nova Scotians who have both identified patterns of harm and suffering within their community and pointed researchers in the direction of improved outcomes for African Nova Scotians living with (dis)Abilities including mental illness and addiction. Their shared observations and experiences identify key barriers to remove and bridges to be built if African Nova Scotians who are caught at the intersection of race and (dis)Ability are to have access to timely and effective care. The article concludes with discussion of pathways to empowerment for those caught at the intersection of race and disability oppression

Keywords: intersectionality, race, disability, empowerment

Dr. Wanda Thomas Bernard is a Canadian senator and is a highly regarded social worker, educator, researcher, community activist and advocate of social change. Bernard is the first Black Canadian to have an academic tenure position and become a full professor at Dalhousie University, where her research focuses on anti-oppression and diversity.

Rajean Willis has been a social worker for 10 years and has been fighting for social justice for as long as she can remember. Her professional experience includes both community and clinical practice and she has worked with a very diverse intergenerational clientele including youth, seniors, mandated and voluntary clients.

Kimberly Berry is a white settler living in Kjipuktuk in Mi'kma'ki (Halifax, Nova Scotia). She has a Ph.D. in History and works as a Senior Evaluator with the Office of Workplace Mental Health for the Nova Scotia Government.

Descriptions of intersectionality frequently rely on images of roads and intersections to represent how multiple systems of oppression converge. In these metaphors, roads represent the route by which negative forces of exploitation and oppression travel and interact. Roads and paths can also be used to represent an egress route taken to escape harm and move toward something better. This paper presents the voices of African Nova Scotians (ANS) who have both identified patterns of harm and suffering within their community and pointed researchers in the direction of improved outcomes for African Nova Scotians living with (dis)Abilities including mental illness and addiction. Their shared observations and experiences identify key barriers to remove and bridges to be built if African Nova Scotians who are caught at the intersection of race and (dis)Ability are to have access to timely and effective care.

Between 2013 and 2015, the Nova Scotia Association of Black Social Workers (NSABSW) conducted a participant action research (PAR) study, which helped to fill gaps in the scholarship on intersectionality, racism, and ableism. The study also provided vital opportunities for grassroots community engagement, education, and empowerment on race and (dis)Ability issues in Nova Scotia. The study, called *Out of the Shadows*, focused on issues of mental illness, substance abuse, problem gambling and (dis)Ability within the ANS community, with the goal of bringing greater awareness to stakeholders in both the African diaspora and the (dis)Ability communities. This paper shares the voices of African Nova Scotian participants in the study, acknowledges the profound and complex harms that result from the intersection of race and (dis)Ability, and considers strategies to mitigate these harms.

What We Already Know: A Brief Review of the Literature

Despite the long and complex history of racism and ableism in Canada, there is not much written about the connection between these two oppressive systems. Scholarship in the United States offers considerably greater examination of this topic. As early as 1998, Faye Z. Belgrave contended that almost all African American families are affected by (dis)Ability and/or mental health concerns. Taylor (2008) found that, particularly as they age, people of African descent suffer higher rates of (dis)Ability than the population as a whole. In their examination of health service statistics, Warner and Brown (2011) found an obvious race and gender-based hierarchy within age trajectories of (dis)Ability. This hierarchy coincides with the racialized and gendered hierarchy, with White males experiencing the lowest levels of (dis)Ability and Black women experiencing the highest levels of (dis)Ability. According to Frederick and Shifrer (2019), the medical model of (dis)Ability sees (dis)Ability as a problem that is located in the body of an individual. The medical model of (dis)Ability regards inequalities faced by individuals as natural consequences of problematic bodies. The social model identifies ableism as the source of these inequalities, including disproportionate rates of unemployment and poverty. In 2014, only 17% of working-age people with (dis)Abilities were employed, compared with 65% of those without (dis)Abilities (Frederick & Shifrer, 2019, pp. 201). In Canada, people reporting a (dis)Ability makeup over 40% of the low-income population, and approximately 25% of people reporting a (dis)Ability earn less than one-half of the national median income (Wall, 2017, pp. 6). Similarly, Lo et al. (2014) showed "chronic mental illness is more prevalent among African American

populations than Caucasian populations" (p. 254) and suggest rather than a purely medical phenomenon, mental illness stems from low socioeconomic status and is therefore a result of systemic racism.

Anglin et al. (2006) found that stigma and attitudes toward mental illness within communities of African descent differ from the dominant community in significant ways. For example, African Americans are more likely to believe that people with mental illness are prone to violence toward others. Yet, African Americans were also found less likely to blame the individual for their violent acts or call for punishment (Anglin et al., 2006).

Kiecolt et al. (2008) argued that African Canadian and African American communities experience similar or lower levels of serious mental illness despite higher exposure to chronic stressors such as low socioeconomic status and racism. Some scholars contend that research methods used to study mental health in these communities are biased toward dominant groups and, therefore, produce inherently flawed results when examining African American populations (Mouzon, 2013).

Indisputably, the experience of African Canadian and African American individuals in relation to health care generally, and to (dis)Ability including mental illness specifically, is set within the context of medical and health care systems, which are themselves characterized by a long history of exploitative and violently oppressive racism. Indeed, many African Canadians encounter profoundly negative experiences when they seek services and support from the health care system (Beagan et al., 2012; Maddalena et al., 2013). These experiences are rooted in a history of unequal access to mainstream services for African Canadians

(Este & Bernard, 2003; Pachai, 1990). Krakauer et al. (2002) explains:

> The history of American medicine includes torturous exploitation, deception, withholding of needed treatment, experimentation without consent, coerced treatment, and stigmatization, perpetuated by healthcare institutions and physicians upon African American and other minority patients. (p. 186)

These are not only problems of the past. MacDonald and Friars (2009) found that even in the contemporary context, people in helping professions cause significant harm to people with (dis)Abilities because of their lack of insight and understanding of attitudes of ableism and racism, and the intersectionality of both. Danzer (2012) makes similar observations about how historically rooted trauma manifests barriers to therapeutic engagement when African Americans are paired with White therapists. Not surprisingly, while problems with historic and systemic racism and ableism linger within health care, a well-founded mistrust of medical and mental health professionals persists among many people of African descent (Dossa, 2005; Burke, 2008; Gamble, 1993; Bhopal, 1998; Krakauer & Truog, 1997). Like all barriers to care, this mistrust can prevent individuals from seeking care until a crisis is imminent (Maddalena et al., 2013). For people with (dis)Abilities, other similar historic and systemic barriers endure. For example, it remains common practice for individuals with (dis)Abilities to be denied rights and opportunities allotted to typically abled individuals. In the case of decisions about resuscitation being made without consent or discussion with the individual, medical practice threatens a "modern-day extinction of people with (dis)Abilities" (Stienstra &

Wight-Felske, 2003, as cited in MacDonald & Friars, 2009, p. 130).

When looking at the intersection of race and disability, the murder of Eric Garner at the hands of a police officer can be used as a case study. Eric Garner was a 47-year-old Black man who was killed in 2014 in an act of homicide by a White New York police officer. This incident was filmed by a bystander. The video showed Garner complaining of police harassment and subsequently being wrestled to the ground by an officer who wraps his arms tightly around Garner's neck (Ogden, Fulambarker, Haggerty, 2020). Completely immobilized, Garner struggles to repeat the phrase, "I can't breathe," 11 times. The video later shows Garner's body lying lifeless on the sidewalk for a full eight minutes (Ogden, Fulambarker, Haggerty, 2020). The medical examiner's report clearly ruled the cause of death as homicide resulting from a chokehold maneuver that led to the compression of his chest and throat (Ogden, Fulambarker, Haggerty, 2020). Garner's social identities as a Black man and a person (dis)Abled by obesity and asthma make the story of his homicide, and its media coverage, an ideal and tragic case for examining the compounding effects of structural racism and ableism (Ogden, Fulambarker, Haggerty, 2020). For Garner, the intersection of race and ableism had an impact on his life and his death. Unconscious biases that stem from this stigmatizing process, wherein the normalization of Whiteness and ability result in Blackness and (dis)Ability being labeled as deviant (Ogden, Fulambarker, Haggerty, 2020). His intersectional identities also contributed to the societal response to his homicide. Those caught at the intersection of race and (dis)Ability face more barriers and challenges because of their social locations.

The intersection of race and (dis)Ability remains a neglected area in sociology, even though racism and ableism are powerful interacting forces in contemporary issues (Frederick & Shifrer, 2019). Despite the critical importance of the topic, significant gaps in scholarship in this field remain. There is a scarcity of scholarship about (dis)Abilities that includes a race analysis, and much of the scholarship on the experiences of Black people excludes the realities of those with (dis)Abilities, rendering exclusion the norm in both communities. There are relatively few explorations of the impact of intersecting social and cultural identities, an absence of first-person experiential accounts, few studies within the Canadian context (Dossa, 2005), and a complete absence of robust study within Nova Scotia specifically. Hence the need for this study.

The Out of the Shadows Project

The *Out of the Shadows* project engaged participants from across the province to explore perceptions and experiences of (dis)Abilities including mental illness and addictions among African Nova Scotians—essentially moving their realities out of the shadows. Participants included both Black Nova Scotians with multi-generational history and recent African immigrants. Those multi-generation Black Nova Scotians are descendants of members of the African diaspora who made their way to this province in several key migrations during the second half of the 18th century and throughout the 1800s. These waves of migration included enslaved individuals among the New England Planters in the 1760s; Black Loyalists between 1782 and 1784; Jamaican Maroons exiled in 1796; Black refugees of the War of 1812; and Caribbean immigrants who immigrated to Cape Breton during the 1890s (African

Nova Scotian Tourism Network, 2013). The African immigrants in this study are individuals who migrated from Africa within the two decades preceding the *Out of the Shadows* study. For the purpose of this paper, all participants of African descent who resided in Nova Scotia, whether indigenous or recent immigrant, are identified as African Nova Scotian (ANS). By virtue of their racialized identity in the context of the historical and ongoing racism in Nova Scotia, all African Nova Scotians are an oppressed group.

Initially, the *Out of the Shadows* study focused on issues of mental illness, substance abuse and problem gambling within the Indigenous Black Nova Scotian population. In response to participant comments, the study expanded to include both New Canadians and African Nova Scotians living with (dis)Abilities. In total, the project engaged 145 participants in eleven communities through three participant engagement methods: kitchen table talks, youth focus groups, and individual interviews.

The participatory action research approach (PAR) is a critical component of the study. Research conducted within the ANS community must be both with and for the people. It is essential to establish a level of trust and understanding between participants and researchers in order to achieve an authentically mutual goal. PAR is characterized by three features: shared ownership of the research project, community-based analysis of social problems, and an orientation toward community action and change (Etowa et al., 2007; Kemmis & McTaggart, 2000). Due to the emphasis on the experiences of participants, the PAR approach is in keeping with Africentric social work values. For this study, PAR ensured that the research was

conducted in a culturally appropriate manner, and that the process and findings aligned with the values of the ANS community. The PAR approach also ensured that the research outcomes can be used to influence change, whether through future research or to inform and influence policy discourse and decision making. Other social research methods which seek to include community in the research design and process do not hold community action and change as an intentional, deliberate component.

The project began with the identification of community leaders within eleven communities throughout Nova Scotia. These local "hosts" organized kitchen table talks either at their own home or at a community focused venue. The hosts played a key role in establishing trust and collaboration between participants and researchers. They also facilitated the recruitment of participants who would feel safe enough to share their experiences of the intersectionality of race and (dis)Ability. Specific hosts were identified to facilitate sessions with groups of youth held at local junior high schools. Each session also included an ANS health care professional as a guest speaker, which created a valuable opportunity for these health care workers to hear firsthand the challenges and concerns of the ANS community. These sessions also allowed community members an opportunity to gather information about what services and supports are available, and to see their racial and cultural identity represented in a participating health care professional. Whether formally, through culturally specific community-driven programs and initiatives (Boudreau, 2015), or informally, through personal accounts of the importance of cultural representation, the ANS community recognizes the value of

mentorship models for improving trust and engagement with health care professionals.

What We Learned from Participants

The study found that racialized ideas and experiences commonly prevent ANS individuals from either seeking or receiving effective intervention or treatments for issues related to (dis)Abilities including mental illness and addictions. African Nova Scotia participants repeatedly expressed concern that delays in effective intervention and treatment for these issues result in a prolonged lack of well-being and in poorer outcomes. They consistently described how African Nova Scotians living with (dis)Abilities, mental illness, and addiction to drugs, alcohol, and/or problem gambling were too often in need of more immediate and more appropriate care. They described a path to treatment and well-being that is filled with barriers and too often missing bridges which might ease access to effective intervention and timely treatment. Two major themes emerged through the analysis of the findings: barriers to care and effective interventions. Each of these themes is discussed in more detail below.

Barriers to Care

Amid the descriptions of the barriers to timely and effective care, two key sub-themes emerged: stigma and access. Experiences related to stigma, judgement, ostracization, and discrimination encountered by individuals living with issues of (dis)Abilities, mental illness, and/or addiction loomed large in participant discussions. Participants described how individuals have attempted to protect themselves and their loved ones from stigma with strategies of silence and denial. They shared stories of how stigma has been internalized to produce embarrassment and

shame. Chief among the strategies to protect against the stings of stigma and shame were to hide, to minimize, and/or to deny that the issues existed. Participants indicated that fear of stigma has played a significant role in the custom of silence and secrecy which has been taught, practiced, and enforced around these issues for generations. The following stories are examples of the power of silence and stigma:

> The Black race is very private, proud group … [we] do not talk about it … [I]n our culture we have to be strong … back in the day it was not acceptable to talk about certain things. (Romaine)

> [I]n our community you're brought up … with the idea that, what goes on at home stays at home … that's very much entrenched in us … you're taught that it's a negative thing [and] you're not going to talk about it … you cover it up. (Marquel)

Participants also indicated that fear of stigma, judgement, and rejection has been a driving force behind the hyper concerns about confidentiality which many had observed within the ANS community. Unfortunately, in what has become a vicious circle, the silence and secrecy employed to protect people from the damage of stigma and judgement has also inhibited awareness, knowledge and understanding of these issues. In the absence of good information and proper understanding, ignorance and misperceptions about these issues has flourished; this in turn has fed the stigma, judgement, and discrimination which prompted the silence in the first place. Just as stigma has prompted silence, the silence has promoted stigma. This cycle leads to a lack of intervention or access to care to properly address the (dis)Ability issue.

The second key sub-theme related to barriers to care is the issue of access. Participants identified a variety of ways in which access to services and resources has been hampered for African Nova Scotians. They spoke about the absence of services and resources located within the ANS community, the costs and challenges associated with travel to communities where services have been available, the barriers related to interpreting and navigating the spaces where services were provided, the racial and cultural barriers which have existed between patients and practitioners, and the communication barriers created by the medical jargon and terminology. Participants shared experiences of racialized discrimination within the health care system. They also shared examples of ways in which the health care system and care providers have failed to deliver effective intervention and timely treatment.

It is important to note that all of these barriers, whether related to stigma or to access, were profoundly racialized. Perhaps the most powerful example of the racialized nature in which issues of (dis)Abilities have been conceptualized and experienced was found in participants' descriptions of ANS perceptions of mental illness and related issues.

Participants described a common impression or belief among many African Nova Scotians that issues related to mental health were not relevant within the ANS community. They explained that issues of (dis)Ability, mental illness, and addiction were seen by many African Nova Scotians as *White* problems. Furthermore, because of the racialized nature of the health care system, many African Nova Scotians have concluded that the supports, services, and treatments available only offer solutions for *White* people. One participant, Hanna,

commented, "You would never think in the Black community, in terms of mental health … they don't think they could have a mental health issue." Another participant, Able, stated, "[B]esides our community … healthcare [was White] … that's who [you] see … working in the hospitals, and it's pretty much the same now … it's still predominantly White professionals." Participants noted that the inability to find culturally relevant treatment services leaves many without services. Many must find interventions on their own or in their communities.

Effective Interventions

Perhaps because of the many challenges to accessing professional care, participants described a long tradition of care and support within their community. One participant, Krys, stated, "I was able to effectively take control of my own life [because] I've been supported by the Black community." Another participant, Jimmy, described his family support, "Everyone in my family supported me the best way they knew how." Several participants found support through programs, organizations, and institutions connected to the ANS community such the Transition Year Program (TYP) at Dalhousie University, the Nova Scotia Association of Black Social Workers (NSABSW), and their local churches:

> [Community leaders at TYP] were always accessible and you knew that they were always around, and you knew [at] key moments … you might interact with them and get ... support ... in your decision. (Tyrell)

> I [found my friends and NSABSW] very supportive … I had some friends …

someone to hear me out, listen to me. (Hanna)

Church supports and stuff like that is what really helped me out. Spirituality took me to where I'm at today, more so than anything. (Dre)

Although community and family support has been invaluable for many people, there are limits to the amount of protection and intervention some individuals receive. With the advantage of hindsight, some participants questioned whether the support they received within the ANS community was adequate:

[the person] who raised me, whom I loved, I talk about him all the time, but the reality … is—he didn't help me. I was in that situation for years and he didn't do anything to pull me out. So, I … had to ride that wave by myself. (Marlene)

Community in those days [would just say] 'that's [name], that's what she's like.' But the behaviour was so erratic and bizarre that [I have to ask] why didn't somebody identify that something was wrong? (Romaine)

While helpers among family and community members were not always the most qualified or informed practitioners of therapeutic support, they were sometimes the only trusted support available.

Historically, mainstream medical care was even less accessible (Spigner, 2007; Krakauer et al., 2002); therefore, people of African descent employed the practices and treatments which were most familiar and available. As one participant, Junior, described: "[W]e learn[ed] to deal with it [and] we deal with it in our own way."

Participants also indicated that many ANS individuals have long benefited from the emotional, psychological, and spiritual support found in their religious faith. Participants spoke about the healing benefits of their faith. Like the findings from Este and Bernard (2006) and Bernard (2009), spirituality was a key strategy used by people of African descent to manage and cope with stressors in their lives, including challenges they faced in dealing with a myriad of health-related issues. Many participants in this study told a similar story. One participant, Jemar, stated, "For us in the Black community [we go to church and the] Lord." Another participant, Roxanne, mentioned, "[the] church [and] the spiritual part that was a great support … that foundation and [direction to] stay on that path—that positive path." Other participants spoke about their experiences of finding critical support within their faith and through prayer, similar to the women in the Began et al. (2012) study:

I had to use the Word [the word of God] … [be]cause the Word is more powerful than any of that stuff … when I had a problem, I had Deacon come pray with me and I felt so much better afterward and so much stronger. (Martin)

All the work programs are great and all that was God's way of showing me the line of where I should be going. (Dre)

At least one participant expressed concern that the church and spirituality declined as an alternative and/or concurrent source of support. They noted that it left ANS community members with fewer resources and supports for their health and well-being: One participant, Tyrell, stated, "Unfortunately, … there's a decline in the participation … in the faith and so the African Nova Scotian—people of African

descent, [are] losing that form of support." Participants also acknowledged occasions when faith and spirituality contributed to the stigma associated with mental illness:

> In the Black community, like growing up in the church, it was shameful if you admitted that you were depressed … because you shouldn't be because you have the Lord, right? (Junior)

> I have been a faithful person in God and Jesus. I would even wonder if I was being punished for being the way I was and acting the way I was. (Martin)

For many in the community, church and faith have been a double-edged sword. Some participants acknowledged that the message delivered from the pulpit has, at times, discouraged individuals from seeking services and treatments for (dis)Ability, mental illness, and/or addiction. Others have noted such complexities regarding the relationship between the African community and the church (Maddalena et al., 2013; James et al., 2010). Once again, citing delay as a concern, participants described situations where religious or spiritual explanations may have delayed more appropriate and effective interventions:

> [I]n our community, there have been times [when] a person [has been] under so much … distress [and] anxiety … [but] people [have] misinterpret[ed] all together, they [have seen] it as … a religious thing. … They have [had] a complete misunderstanding of it altogether … interpret[ed] it entirely wrong and … maybe someone could have, perhaps, found help … [but] that misinterpretation [lead] to more devastation because nobody step[ped] in. (Jemar)

Conversely, several participants recognized that well informed and supportive church leaders can play a critical role in the provision of culturally appropriate and accessible resources within the ANS community:

> [The] more informed … pastors or … ministers … will know how to approach it in a way that's going to be effective, and sometimes the Lord will say … go to the doctor … I provided means for you [to access help]. (Tyrell)

> [W]e have a minister now that is really working and encouraging people to deal with the pain, and creating opportunities for people in small groups, and support groups and so on … to address whatever issues that are going on in their lives … she's creating many, many opportunities for those things to happen. (Antione)

In terms of trust, cultural safety, and physical accessibility, local ANS churches are among the most obvious locations to engage community members, provide information, strengthen awareness, and offer support.

Some participants spoke about the interventions both within the ANS community and in the broader health care system which have worked well. Several participants pointed to the benefits of receiving care which was culturally relevant. Able noted, "if [the practitioners] are their culture, it's easier to relate and it makes you feel more comfortable … talking to them." Another participant described his experience with an African Nova Scotian counsellor:

> [An ANS counsellor] was the only person [I really connected with], because you know why, he was there before me, what he went through [mirrored my

experience] … so when I had him as a counsellor, I felt comfortable … I was fortunate to have [an ANS counsellor] … that helped me tremendously. (Dre)

In addition to the powerfully positive experiences of dealing with practitioners who share a cultural identity and connection with their clients, participants discussed the value of connecting with peers who are of African descent and are living with similar experiences. Several participants with experiences related to a specific genetic condition described the positive experience of meeting and talking to other individuals of African descent or family members who share the same condition, if not always the same experience.

While the profound benefits of shared identity cannot be replaced, some participants found some White professionals who demonstrated the ability to listen to and appreciate the experience of ANS clients. One participant described her experience:

I told my counsellor [about] my situation … the generation I grew up with, the fact that I am a woman, and that I am Black … I explained to him some [of] the racial things I went through as I was growing up and he was very receptive and open to that. I don't know if he [had] any training in cultural competency … but I really felt that he listened to me. (Roxanne)

It is possible for health care practitioners to reach beyond their own gendered and racialized experiences and to listen to and learn from the experiences of their clients. However, it appears from the discussions with participants, this skill is not commonly demonstrated among the health care practitioners encountered by many African Nova Scotians. Nevertheless, it is a critical

component in strengthening the quality of care offered to everyone in the province.

A Path to Empowerment

In addition to their comments on strategies and practices that have worked well, participants identified a number of areas which need improvement in order to ensure that ANS have access to better care, sooner. To address the issues of physical accessibility of services, participants called for improved transportation and better integration of the ANS community with the available supports and services. Most significantly, ANS participants recognized that the path forward must address barriers related to the physical location of supports and services:

I would love to see, more than anything, is a way for us to get around the community more and not feel isolated from town … I want to see … the community not being treated so much [like] a shadow. (Martin)

… [J]ust having a safe place that they can come and just being able to come and just talk [and] also to get support … it would be good for that support to be … in the Black community. (Marlene)

Not surprisingly, many participants identified "breaking the silence" as a critical component of effective interventions and key to strengthening well-being within the ANS community. Mindful of what often prompts silence, some participants called for individuals to overcome the fear of judgement and better inform themselves in order to help others.

Indeed, many participants indicated that breaking the silence must be the first step toward overcoming the isolation and harms

associated with (dis)Abilities, mental illness, and addiction and how they intersect with race and racism for people of African descent:

> Once it's on the outside [out in the open], there's people out there that know people … know places … [and know] other people [who] have gone through the same thing. (Jemar)

> … [E]ducate families, so that they will be able to come out and then let people know exactly what is wrong with them, [then] we would really be able to understand them better. (Zhuri)

> … [There is] trauma that the communities have faced [that] haven't been dealt with … we really need to have healing in our communities. (Mabel)

Participants recognized that more open communication and education about these issues are essential to the elimination of stigma. As Roxanne stated, "Just being able to talk about it relieves some of the stigma." Stigma not only prevents individuals from seeking help, but does damage in and of itself. Stigma harms self-esteem and undermines well-being. One participant described the importance of communication and education:

> Information sharing … is one of the most powerful tools for social inclusion … through workshops, community talks, radio talk shows, [this is the] first step in addressing this issue … people need to be empowered with information. (Mohammad)

Several participants also wished to enhance their own knowledge of these issues to more effectively offer support and assistance to others in their community:

> I'd like to learn more [and have] training in the [area of] mental health. (Hanna)

> … [A] lot of people don't know how to approach it, and that's the thing that we need to be educated. (Krys)

> … [I]f we had more specifics around the types of (dis)Abilities within the Black community and how we should be addressing them. (Marlene)

In addition to kitchen table talks, support groups, and other opportunities for increased education, participants raised the need to identify helpers and supports within the community. As one participant, Dee, stated, "Set something up … something within the community, so that people would know who to contact if they ran into some kind of problem. Like a 'go-to' person."

Another element which participants identified as critical in creating effective solutions was a shared cultural connection between those who seek support and those who provide it:

> Getting more professionals in the field would help for sure as far as the stigma within the community itself. It's been proven that people are a little more forthcoming when the individuals understand them or look like them. Getting more minorities interfacing with the mental health system … that would be great. (Shauna)

A shared cultural connection was sometimes tied to the issue of trust. As another participant, Tyrell, stated, "I would like to see … more Black [practitioners] … being a Black male, [I] can relate to [others] of our own culture and our own people. It's really a trust issue."

Participants identified trust in health care practitioners and treatment as critical to improving access to effective interventions. Dee noted, "African Nova Scotians … need to know that they can trust [the health care practitioner] because some people they just don't trust." Several participants recognized the value of building trust and establishing relationships with health care professionals before a crisis arises:

> … [T]hey're trying to [bridge] gaps with police officers. They're trying to show that police officers are their friends— [they're] not just here to arrest you. So, it should be the same kind of approach [with mental health professionals]. (Junior)

> … [W]e are relationship people … we require to know someone whether it is a professional or paraprofessional or someone in the helping field—we require to know them a little bit before we will trust them. (Dre)

At least one participant identified the importance of having practitioners who are deeply committed to finding solutions:

> We need the right people out there working … not just for that forty-hour week [attitude]—'I'm here to punch in and punch out' … [we need] people like [my African Nova Scotian counsellor] that actually care. That's what we need … more hands-on people like that. (Antione)

Certainly, issues related to (dis)Abilities including mental illness and addiction do not affect people's lives strictly within the limits of regular business hours. Similarly, the challenges of overcoming a long history of oppression and discrimination surely warrant a degree of commitment which is not neatly contained within regular business hours. Without a doubt, the observations and experiences of the participants indicate that practitioners who demonstrate a deeper degree of connection and commitment might also warrant the trust of ANS who seek their support.

Perhaps the other side of the same coin was identified by participants who called for better engagement among African Nova Scotians with the many services and resources which are currently available.

Participants described the benefits of support received within the ANS community, from friends and family, and from programs and organizations connected to the community such as TYP at Dalhousie, NSABSW, or the Church. Given the value and importance placed on cultural identity, the degree of trust which already exists among one's friends and family, and the immediate accessibility of these supports, it should come as no surprise that these supports have been effectively employed for the benefit of many individuals. However, participants identified critical limitations within these supports. Stigma, judgement, shame, and silence have undermined even these culturally connected and trusted supports. Limitations related to the knowledge and understanding of the issues, their proper diagnosis, and effective treatment were also problems within many community-based support systems. These limitations included ill-informed and often hurtful comments from others and the message that the only intervention necessary to address (dis)Abilities, mental illness, or addiction is faith in God.

In addition to community-based support, participants identified a variety of therapeutic interventions and support programs which have benefited individuals

and their loved ones. Again, many participants described the benefits of engaging with service providers and peer supporters who share the same racialized identity.

In summary, participants identified several critical elements to strengthen the well-being of African Nova Scotians living with (dis)Abilities, mental illness, and/or addictions. Most notably was the need for increased and permanent presence of programs and services located within ANS communities. Breaking the silence which shrouds these issues was raised as key to improving access to support, and the first step in eliminating the associated stigma. Many participants suggested community-based support groups as an effective method to break the silence, eliminate stigma, and help enhance awareness and understanding about these issues within the ANS community. Trust was highlighted as an integral part of the relationship with health care providers; the presence of ANS practitioners was specified as vital to building this trust. Of course, participants also recognized the value of culturally competent non-ANS practitioners and called for measures which would increase the quality and quantity of truly culturally competent care providers. Finally, there was recognition that commitment and engagement on the part of both health care providers and members of the ANS community are vital to the improvement of well-being among community members who live with (dis)Abilities, mental illness, and/or addictions.

Discussion and Conclusion

In 2013, the United Nations General Assembly proclaimed 2015 to 2024 the International Decade for People of African Descent (UNIDPAD) with the theme:

"People of African descent: recognition, justice and development". That same year, NSABSW launched its *Out of the Shadows* project; a study that advances our understanding of intersectionality through the examination of the convergence of racism and ableism. Not coincidentally, the findings of this study align precisely with the objectives and key activities laid out by the UNIDPAD.

The voices of African Nova Scotians reaffirm Frederick and Shifrer's (2019) assertion that racism and ableism are powerful interacting forces that impact the everyday lives of persons caught at their intersection. They recount a litany of barriers to accessible, respectful, and culturally appropriate health care. From their description of these obstacles, two central themes emerged: stigma and access. Participants indicate that stigma triggers fear and prompts defenses of silence and denial. These elements—stigma, fear, silence, and denial—are either rooted in or connected to racism and ableism and construct significant barriers to care. These observations favor those of Anglin et al. (2006) who found racialized differences in stigmatizing attitudes toward individuals with mental illness.

Related to stigma, and similar to silence, is invisibility. African Nova Scotians do not see themselves meaningfully represented within the health care system, either as providers or as recipients of care. Study participants identified additional impediments including location of services, hours of operation, spaces and systems that are difficult to navigate, and service providers who are discriminatory and dismissive. They described how these barriers, as well as gaps in cultural values and practices, conspire to render access to care at best challenging and at worst

impossible. Moreover, they indicated that once they are connected to health care institutions and practitioners, their experiences too often range from uncomfortable to harmful. The negative experiences of African Nova Scotians in the health care system echo the findings of MacDonald and Friars (2009), Danzer (2012), and Halloran (2018) asserting that the lack of knowledge about the intersection of race and (dis)Ability within the health care system and among its practitioners causes harm.

The voices of African Nova Scotians have joined a chorus of others calling out the physical and mental health harms of racism. The list includes, but is not limited to, James, Este, Bernard, Benjamin, Lloyd, and Turner (2010); Warner and Brown (2011); Beagan, Etowa, and Bernard (2012); Lo, Cheng and Howell (2014); Grills, Aird, and Rowe (2016); Sule, Sutton, Jones, Moore, and Igbo (2017); and Carlson, Endlsey, Motley, Shawahin, and Williams (2018). Like Danzer (2012), the voices in this study are calling-in clinicians to "deeply and objectively" examine how their understanding of race, ableism, and Africentric values manifest in their practice.

Despite the barriers and challenges, participants identified important protective factors and pathways to change. When the first voices in this study describe protective factors in their lives, such as Church, religious faith, and community-driven support, they echo the findings of James et al. (2010), Beagan et al. (2012), and Maddalena et al. (2013). Closer to home, Boudreau (2015) found that culturally specific community driven (CSCD) programs offered an abundance of support to members of the ANS community over their life journeys in a variety of ways, including coping with racism, and provided

a positive impact on their health and well-being. In fact, CSCD programs were identified as necessary supports that contributed to the health and well-being of all study participants (p.149). An excellent example of how community-driven programs can offer prompt, equitable, community-based support is found in the NSABSW emergency response to ANS communities caught in colliding pandemics of racism and COVID-19 (Bernard, 2020).

This study identifies critical changes necessary for effective intervention and treatment to reduce the harms of (dis)Ability, racism, mental illness, and addiction in the ANS community. While key steps include the need to break the silence, increase discussion, and reduce stigma; there are also critical changes needed at the institutional and state level. In accordance with the UNIDPAD objectives and activities, this study finds that the state and health care institutions must implement policies to combat racism and take action to remove the obstacles that prevent equitable access to appropriate health care (General Assembly, 2014). This requires the collection, compilation, analysis, dissemination, and publication of reliable statistical data to measure the success of action taken to redress racism, discrimination, and intolerance in the health care system (General Assembly, 2014). This study also points to the need for a national plan of action to promote equitable access to health care and create conditions for all people of African descent to effectively participate as both recipients and providers of effective and appropriate, culturally responsive health care.

This study brings the reality of African Nova Scotians with (dis)Abilities out of the shadows. It signals the need for changes to ensure the inclusion and empowerment of

all African Nova Scotians. It is imperative to both recognize and redress barriers constructed from historic and ongoing racism and ableism. In essence, these can be developed as strategic actions under the three pillars of the UNIDPAD: recognition, justice, and development. Such pathways could also be considered as forms of reparations that are implemented by health care systems to help repair the multigenerational harms caused by those systems. The path toward timely, effective, and equitable health care requires more ANS practitioners at all levels of care, community-driven support and services, more effective training to strengthen cultural humility among non-ANS service providers, more Africentric models of practice, and critical policy changes that both recognize and redress historic and ongoing harms.

References

African Nova Scotian Tourism Network (2013). *Cultural assets of Nova Scotia: African Nova Scotian tourism guide*. African Nova Scotian Tourism Network.

Anglin, D., Link, B., & Phelan, J. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services*, *57*(6).

Beagan, B. L., Etowa, J., & Bernard, W. T. (2012). "With God in our lives he gives us the strength to carry on": African Nova Scotian women, spirituality, and racism-related stress. Mental Health, Religion & Culture, *15*(2), 103–120. https://doi.org/10.1080/13674676.2011.560145

Belgrave. F.Z. (1998). Psychosocial aspects of chronic illness and disability among African Americans. Auburn House.

Bernard, W.T. (2009). Black men in the diaspora: Resilient and surviving but still catching Hell. *International Social Work*, James, G.G., Ramsay, R., and Drover, G (Editors), Thompson Educational Publishing, 81-102.

Bernard, W.T. (2020). When two pandemics collide: Racism, COVID-19 and the Association of Black Social Workers emergency response. *Canadian Social Work Review, 37*(2) 175-183.

Bhopal, R. (1998). Spectre of racism in health and health care: Lessons from history and the United States. *British Medical Journal*, *316*(7149), 1970-1973. https://doi.org/10.1136/bmj.316.7149.1970

Boudreau, R.N. (2015). Exploring the impacts of culturally specific community-driven programs on the life journey of African Nova Scotians [Unpublished master's thesis]. Dalhousie University.

Burke, D. (2008). *Crisis in the community: The African Caribbean experience of mental health*. Chipmunka Publishing.

Carlson, M., Endlsey, M., Hines, E. Jr., Motley, D., Shawahin, L. N., & Williams, M. T. (2018). Addressing the impact of racism on veterans of color: A race-based stress and trauma intervention. *Psychology of Violence, 8*(6), 748-762. http://dx.doi.org/10.1037/vio0000221

Danzer, G. (2012). African-American's historical trauma: Manifestations in and outside of therapy. *The Journal of Theory Construction & Testing, 16*(1), 16-21.

Dossa, P. (2005). Racialized bodies, disabling words. *Social Science & Medicine*, *60*(11). 2527-2536.

Este, D., & Bernard, W.T. (2003). Social work practice with African Canadians: An examination of the African-Nova Scotian community. In Graham and Al-Krenawi (Eds.) *Multicultural Social Work Practice* (pp. 306-337). Oxford University Press.

Este, D., & Bernard, W.T. (2006) Spirituality among African Nova Scotians: A key to survival in Canadian society. *Critical Social Work, 7*(1), 1-22.

Etowa, Josephine & Wiens, Juliana & Bernard, Wanda & Clow, Barbara. (2007). Determinants of Black women's health in rural and remote communities. The Canadian journal of nursing research/Revue canadienne de recherche en sciences infirmières. 39. 56-76.

Frederick, A., & Shifrer, D. (2019). Race and disability: From analogy to intersectionality. *Moving Sociology of Race and Ethnicity Forward, 5(2),* 200-214. https://doi.org/10.1177/2332649218783480

Gamble V. (1993). A legacy of distrust: African Americans and medical research. *American Journal of Preventive Medicine, 9*(suppl 6), 35-38.

General Assembly (2014) resolution 69/16, Programme of activities for the implementation of the International Decade for People of African Descent, A/RES/69/16.

Grills, C. N., Aird, E. G., & Rowe, D. (2016). Breathe, baby, breathe: Clearing the way for the emotional emancipation of Black people. Cultural Studies ↔ Critical Methodologies, 16(3), 333–343. https://doi.org/10.1177/1532708616634839

Halloran, M.J. (201   8). African American health and posttraumatic slave syndrome: A terror management theory account. *Journal of Black Studies 50*(1), 45-65.

James, Este, D., Bernard, W. T., Benjamin, A., Lloyd, B., & Turner, T. (2014). Race & well-being: The lives, hopes, and activism of African Canadians. Fernwood Publishing.

Kemmis, S., & McTaggart, R. (2000). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 567-607). Thousand Oaks, CA: Sage.

Kiecolt, K., Huges, M., & Keith, V. (2008). Race, social relationships, and mental health. *Journal of Personal Relationships, 15*(2), 229-245.

Krakauer, E. L., Crenner, C., & Fox, K. (2002). Barriers to optimum end of life care for minority patients. *Journal of the American Geriatric Society*, *50*, 182-190.

Krakauer, E.L., & Truog, R.D. (1997). Case study: Mistrust, racism, and end-of-life treatment. Hastings Center Report 27(3):23.

Lo, C., Cheng, T., & Howell, R. (2014) Access to and utilization of health services as pathway to racial disparities in serious mental illness. *Community Mental Health Journal*, *50*, 251-275.

Maddalena, V., Bernard W. T., Etowa, J. B., Davis-Murdoch, S., Smith, D., & Marsh-Jarvis, P. (2013). Assessing the knowledge of African Canadians regarding options available for palliative and end of life care using participatory research. *Journal of Transcultural Nursing*, *24*(2), 144-152.

MacDonald, J. E., & Friars, G. (2009). Structural social work from a (dis)ability perspective. In Hick, S. F., Peters H. I., Corner, T., & Tracy London, T. (Eds.), *Structural social work in action: Examples from practice* (pp. 139-153). Canadian Scholars' Press.

Myers. L. J., & Speight, S.L. (2010). Reframing mental health and psychological well being among persons of African descent: Africana/Black psychology meeting the challenges of fractures social and cultural realities. *The Journal of Pan African Studies*, *iii* (8), 66-82.

Mouzon, D. (2013). Can family relationships explain the race paradox in mental health?. *Journal of Marriage and Family*, *75*(2), 470-485.

Ogden, L. P., Fulambarker, A. J., & Haggerty, C. (2020). Race and disability in media coverage of the police homicide of Eric Garner. *Journal of Social Work Education*, *56*(4), 649-663.

Pachai, B. (1990). *Beneath the clouds of the promised land: The survival of Nova Scotia's Blacks Volume 2. 1800-1989*. Black Educators Association.

Spigner, C. (2007). Race, health, and the African diaspora. *International Quarterly of Community Health Education*, *27* (2), 161-176. Retrieved August 2, 2015, from http://ezproxy.library.dal.ca/login?url=http://search.proquest.com/docview/19528707?accountid=10406.

Sule E, Sutton RM, Jones D, Moore R, Igbo I, Jones LA. The past does matter: A nursing perspective on post traumatic slave syndrome (PTSS). J Racial Ethn Health Disparities. 2017 Jan 11. doi: 10.1007/s40615-016-0328-7. Epub ahead of print. PMID: 28078658.

Taylor, M. G. (2008). Timing, accumulation, and the Black/White disability gap in later life: A test of weathering. *Research on Aging*, *30*(2), 226-250.

Wall, K. (2017). *Insights on Canadian society: Low income among persons with disability in Canada.* Statistics Canada. https://www150.statcan.gc.ca/n1/en/catalogue/75-006-X201700154854

Warner D. & Brown, T., & Warner, D. (2011). Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. Social Science & Medicine, 72(8), 1236-1248.