EXPLORING INSTITUTIONAL LANGUAGE POLICIES PERTAINING TO THE PROVISION OF MENTAL HEALTH SERVICES TO INUIT IN NUNAVUT

ALANA DUNCAN

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Faculty of Arts
University of Ottawa

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Abstract

In 2019, Statistics Canada reported that the death by suicide rate among Inuit in Canada was approximately nine times higher than that of their non-Indigenous counterparts. This alarming statistic reflects the ongoing impact of colonial legacy on Inuit society, which has been characterized as cultural genocide and linguicide (TRC, 2015). In the last two decades, various organizations have taken up efforts to help heal communities, however there is little research examining what makes those efforts effective, and virtually none that has addressed the place of language within mental health programming. Yet, language is a pillar of Inuit health and wellness (ITK, 2016).

This thesis explores institutional language policies pertaining to the provision of mental health services to Inuit in Nunavut from a decolonial perspective. I conduct a document review and six semi-structured interviews to examine which government-funded mental health programs provide services in the Inuit Language, the challenges they face in doing so, and solutions that they may envision. Applying decolonization as both my conceptual and methodological framework, I conduct a thematic analysis of both documents and interviews, as well as a critical discourse analysis combining both sets of data.

The results of this study reveal that mental health service providers serving Nunavut largely have de facto language policies. They attribute challenges to offering Inuit Language programming to the dominance of English, hiring practices and funding models. However, it is demonstrated both in documents and by study participants that organizations have found holistic and inclusive ways to not only offer programming in the Inuit Language, but also encourage and increase its use. Local and cultural knowledge prove to be indispensable in understanding systemic challenges to Inuit Language provision in mental health services, as well as how they can be remediated.

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CHAPTER 1: INTRODUCTION

1.1 Thesis outline

The objective of this thesis is to examine language policies in government-funded institutions that provide mental health services and supports to Inuit in Nunavut. In this chapter, I present an outline of my study as well as situate myself within the context of this research.

In Chapter 2, I provide briefly summarize some of Nunavut's history with colonialism and how it correlates to the current state of mental health among Inuit in the territory. I then introduce the problem and research questions.

In Chapter 3, I first review existing literature on language barriers to healthcare, which I divide into three parts: barriers to access; barriers to communication in therapeutic interventions; and barriers to effective service delivery. To introduce decolonization as my conceptual framework for this study, I begin with a review of key concepts in language policy and planning, including linguistic imperialism and linguicide, which can be used to examine the impact of colonialism on language in society. I then present Western and non-Western research on decolonization in the field of psychology. Lastly, I outline existing models for indigenizing mental health which include language.

In Chapter 4, I explain my methodological framework, including my two-pronged data collection process (policy documents and interviews) and use of mixed-method analysis, combining thematic analysis and critical discourse analysis.

In Chapter 5, I present and discuss findings from my document analysis, followed by the results of the analysis of my semi-structured interviews with six mental health service providers operating in Nunavut. I quote the words of these providers throughout the analysis to amplify and preserve

the authenticity of their experiences and perspectives. Finally, I address the significance of discourse observed in both documents and interviews.

In Chapter 6, I conclude by taking stock of the research presented, discussing its limitations and potential areas for future research.

1.2 Researcher Positioning

I am a Black, second generation Canadian, non-Indigenous scholar with lived Northern experience. From 2017–2019, I had the privilege of living in Yellowknife, Northwest Territories (NWT), and spending time in Iqaluit, Nunavut as a part of my role in coordinating official language policy compliance for a crown corporation operating in both territories. During those 18 months, my knowledge of Canada's social, political, and linguistic landscape evolved, in addition to how I saw my position in it. I witnessed the direct and everlasting impacts of colonialism on First Nations and Inuit and learned to look beyond Western ways of thinking. In Nunavut, I was particularly surprised by the strong allyship of the non-Inuit and their determination to learn, share, and help keep the Inuit culture alive.

When I returned to Ontario to work, I quickly realized that I held more knowledge than my counterparts about Indigenous language policy in the North. I also noticed that the Northern context was seldom brought up in discussions about language policy and practice. This tendency to forget or ignore the North became more apparent with the onset of the COVID-19 pandemic. Government and industry cautioned that the upheaval would adversely impact the mental health of Canadians. Aware of the longstanding and disproportionately high death by suicide rates among Inuit in Canada (which I will summarize later), I was somewhat surprised to hear very little mention of the North. Providing mental health services and supports nationwide should include populations most in need of them. It became clear to me that there was little awareness of not only

the needs and realities of Nunavummiut, but also how to support them, and that this knowledge was essential for true reconciliation.

In both the NWT and Nunavut, Inuit and Inuvialuit met me with particular acceptance and patience. It is difficult to describe the complex feeling of having experienced systemic anti-Black racism myself, to then being in a space where those with even deeper wounds and much less privilege than I were those who received me as though I was allowed to belong.

One of the most important values instilled in me from childhood is “If you have, give.” I have the privilege to work and conduct research in the field of my choice. I have the privilege of being able to support my own mental health in the language that I speak. What I can give through this thesis is my time, knowledge, and voice to a society that has been too long overlooked yet has consistently chosen to extend me grace.

CHAPTER 2: PROBLEM AND RESEARCH QUESTIONS

In this chapter, I introduce and contextualize Inuit mental health challenges in Nunavut within Canada's colonial history. I then briefly comment on the inextricable link between the Inuit Language (also referred to as Inuktut) and well-being as it pertains to language policies in institutions offering mental health services to Inuit in Nunavut. This brief review will lead to formulating the problem and the research questions of this project.

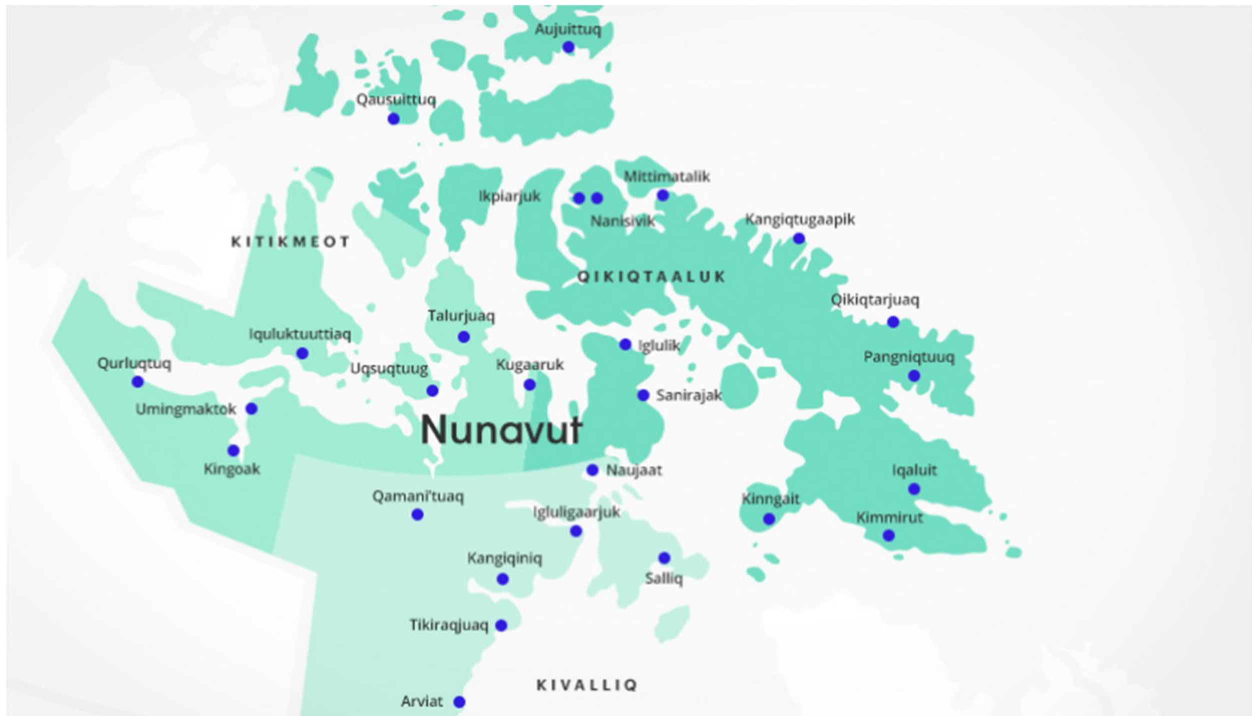

Figure 1: Map of Nunavut (Carrefour Nunavut, 2021)

Figure 1 above presents the geographic scope for this thesis. Nunavut's 25 communities are divided into three regions: Qikitani, Kivalliq, and Kitikmeot. Although Inuit also live in other areas of Canada, including the Northwest Territories, Newfoundland and Labrador, Quebec, and Ontario, I focus on Nunavut because the territorial government has enacted legislation to give the Inuit Language official status as well as protective rights, among which is access to services in the Inuit Language. According to the 2016 Census, Inuit make up 84.7% of Nunavummiut and face

social, political, economic, and environmental challenges that differ from the rest of the country. One of these challenges is mental health, and in particular, high death by suicide rates.

In 2019, Statistics Canada published an eye-opening report on death by suicide rates among First Nations, Métis and Inuit from 2011 to 2016 (Kumar & Tjepkema, 2019). The report revealed that suicide rates are significantly higher among these groups than non-Indigenous people and vary based on several socioeconomic factors as well as by community. On average, death by suicide rates among First Nations were three times higher than the rates among non-Indigenous people. Among Métis, rates were about two times higher. Most alarmingly, among Inuit, rates were approximately nine times higher. The report also indicates that the present mental health challenges facing the Inuit population cannot be examined apart from the history of colonialism and resistance in which they are rooted (Kumar & Tjepkema, 2019).

Colonization's impact on Inuit began in the mid-nineteenth century with whaling expeditions and the fur trade encounters of the early twentieth century. Europeans and Americans brought with them infectious diseases, such as tuberculosis, for which Inuit were unprepared (Kral et al., 2011). Christian missionaries and the Royal Canadian Mounted Police (RCMP) arrived in the mid-twentieth century. From 1953 to 1955, the RCMP moved some 92 Inuit from Northern Quebec and Pond Inlet to two settlements in the High Arctic, dividing families against their will (Madwar, 2018). The High Arctic was called *Qausuittuq*, meaning "place of darkness." It was indeed a dark place, both literally and figuratively. The land was frozen, the little hunting became scavenging, and rules were stringent. Depression set in, and according to some, alcohol became the only way to live in such conditions. This in turn led to domestic violence (Madwar, 2018). Even before this major population displacement and mistreatment, in the 1920s, government-sponsored missionary

schools started to appear in the North[1]. The North's vast landscape meant that Inuit children were institutionalized very far from home, unable to return for months, and sometimes years (Fraser, 2020). Although treatment of the children varied in the northern schools, two schools located in Chesterfield Inlet and Inuvik were notorious for allegations of sexual abuse, runaways and deaths by suicide. They were also among the schools open the longest (Fraser, 2020). In short, the colonial history of Inuit is one of loss of population, land, resources, tradition, and language, now fraught with intergenerational trauma, misunderstanding and power struggles.

In 2016, the Truth and Reconciliation Commission (TRC) of Canada published their final report after a six-year study of the impact of the Indian Residential School System on First Nations, Inuit and Métis in Canada. Following consultations with over 6,000 witnesses, most of whom were survivors, the TRC described what they found as "cultural genocide" (TRC, 2015, p. 1).

With regard to the Inuit Language, the "cultural genocide" of the residential schools also resulted in linguicide (Griffith, 2017). English was the language of instruction across the residential school system. Northern Affairs official R. A. J. Philipps wrote that his department was:

> the most effective protector of the Eskimo cultural tradition. It is prepared to use the local language in the lower grades, but as a matter both of principle and practicality it is heavily committed to English. It is a matter of principle because a liberal education can be achieved only by the use of a major language. (TRC, v2, 2015, p. 92)

English was framed as the legitimate and natural way by the colonizers, while Indigenous languages were seen as a permanent handicap (Griffith, 2017). An incapacity to learn English on the part of Indigenous students was attributed to biological or behavioural dispositions such as

[1] Regions of Canada that are geographically situated north of the 60th parallel.

shyness or cognitive impairment. In many cases, English came to signify survival, employability, communication with more people, and spiritual reassurance.

Despite recent political efforts on the part of the Government of Nunavut to protect and revitalize Inuktut (the Inuit Language), it is still today, along with many other Indigenous languages, considered endangered, with 41,830 speakers across Canada (Statistics Canada, 2017). However, in 2016, 89% of the Inuit population in Nunavut declared themselves able to hold a conversation in the Inuktut (Lepage, Langlois & Turcotte, 2019). Further, 82.3% declared competencies in both Inuktut and English. Although Inuit in Nunavut are, in fact, becoming increasingly bilingual, 76.6% still declared Inuktut as their dominant language (Lepage, Langlois & Turcotte, 2019), which calls for better service provision (including mental health services) in this language.

In an effort to undo the wrongful past, the TRC's findings resulted in 94 calls-to-action to support reconciliation between the Government of Canada and the First Nations, Inuit and Métis. Acknowledging recommendations of previous reports, such as one published in 2007 by the national representational organization for Inuit in Canada, Inuit Tapiriit Kanatami (ITK), which flagged mental wellness as the "single most important health issue for Inuit in Canada" (Anderson, 2015, p. 3), the nineteenth call-to-action urges the federal government to address the gaps in health outcomes between Indigenous and non-Indigenous communities, including mental health and suicide. The twentieth one takes it a step further: "[...] we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples" (TRC, 2016, p. 3).

In the case of mental health, this twentieth call-to-action echoes previous reports, such as the one published in 2010 by the Cultural Safety Working Group, First Nation, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada (FNIM AC MHCC) which noted that "A

tension exists between Indigenous ways of understanding and responding to mental health and illness and the current mental health system, a system dominated by biomedical understandings” (FNIM AC MHCC, 2010, p. 4).

Creating cultural continuity is identified in the National Inuit Suicide Prevention Strategy (ITK, 2016) as one of the six priority areas and aims to foster healing through the development of sustainable approaches to connecting with land, culture, and language. The strategy highlights culture and language as the “cornerstone of Inuit health and wellness” (ITK, 2016, p. 31), to which their people have had limited access or have had to forego to access essential services such as counselling and psychotherapy. ITK thus aims to “support regions in incorporating Inuit culture and language into mental health programming and lead research on Inuit-specific mental health interventions” (ITK, 2016, p. 31). Nunavut’s Suicide Prevention Strategy and Action Plan (*Inuusivut Anninaqtuq*) 2017–2022 (2017a), a joint initiative between the Government of Nunavut (GN), the Royal Canadian Mounted Police (RCMP), Nunavut Tunngavik Incorporated (NTI), and Embrace Life Council, also calls for increased “access to Inuktut-speaking counsellors who provide services rooted in Inuit culture” (p. 15), improved access to interpreters, the development of counselling-specific terminology in Inuktut among their commitments over five years. Further, in 2017, the Department of Health at the Government of Nunavut released a report indicating that community members identified language and lack of terminology as barriers to communication between patients and mental health workers (Government of Nunavut, 2017b).

Despite pressing needs, research on links between language and Inuit-specific mental health programming and interventions is quasi-inexistent. However, research done in other contexts tells us that health and wellness are conceptualized differently and more holistically in Indigenous cultures than in Western medicine (Schmidt, 2019), that language is the instrument by which the

depth of these concepts is expressed (Tagalik, 2010), and that connection to language, culture and community is associated with better health outcomes (Kral, 2016; Newell et al., 2020; Sivak et al., 2019).

Given these research findings, it is troubling to note that, although health care is an essential service, and despite Nunavut's strong language policies, provision of health care in the Inuit Language still appears to be lacking (Office of the Languages Commissioner NU, 2015; Romain, 2017). Indeed, *Nunavut's Official Languages Act* (OLA) states that English, French and Inuktut are the official languages of the territory. Section 3 of the *Inuit Language Protection Act* (ILPA) goes further to stipulate that any organization operating in the territory of Nunavut, whether public, private, territorial or federal, must communicate with and provide services to the public in the official language of their choice. This includes both oral and written public-facing communications, signs, posters, advertisements, etc. Services and communications must be made available simultaneously and with equal prominence in each official language. Section 3 also specifically mentions essential services, which, according to the definition provided, would include mental health services:

> (2) An organization shall communicate with the public in the Inuit Language when delivering the following particular services: (a) essential services, including (i) emergency, rescue or similarly urgent services or interventions, including intake or dispatch services, and (ii) health, medical and pharmaceutical services; (ILPA, 3(2)(a))

Based on this policy document, any mental health service provider offering services to Nunavummiut must have the capacity to render said services in the Inuit Language. It is presently unclear whether Westernized institutions are aware of the importance of language to Inuit and whether their language policies answer this need.

In light of the presented research and acknowledging 1) that language can be considered a barrier to accessing mental health services (Bailey et al., 2020; Bowen, 2015; Office of the Languages Commissioner NU, 2015); 2) institutional aspirations (and perhaps duty) to ensure the mental health of Inuit population (ITK, 2016); and 3) the holistic connection between language, culture and wellness for Inuit (Newell et al., 2020; Schmidt, 2019; Tagalik, 2010), this thesis seeks to explore, through a decolonization lens, the following research question: How does language policy affect the delivery of mental health services to Inuit in Nunavut?

By helping to understand institutional practices and challenges pertaining to the provision of mental health services in the Inuit Language, while raising awareness about the importance and interrelatedness of language and well-being in Inuit culture, this study could not only contribute to the growing body of research on decolonized approaches to mental health programming, but also potentially help Western institutions develop more holistic and decolonized policies that improve access to and quality of mental health services offered to Inuit.

As I will explain in the following chapters of this thesis, while conducting this research, I neither assume the voice of Inuit on their own experiences, nor overlook the work already being done by and for Inuit (e.g., ITK, NTI, community organizations, etc.) to indigenize mental health services. My goal is rather to use both my lived experience in the North and my understanding of Western policy to explore the position of language in publicly funded mental health programs provided to Inuit in Nunavut. I will do this by looking at existing language policies in Western and Inuit institutions through a decolonial lens with the goal of understanding their role in Inuit community life, and in hopes of helping improve the relations and outcomes of mental health services through ongoing indigenization processes undertaken by Inuit. I acknowledge that this research is situated in a complex and multilayered space. The first layer is my relation as the researcher to coloniality.

I am non-Indigenous, a settler, who would like to contribute to the field of Indigenous language policy by attempting to bridge Western and Inuit understandings of language and wellness. The second layer is the space in which this research is conducted. As a student at a Western institution, my work and learning must inevitably adhere to Eurocentric policies and definitions of knowledge, ethics, and research. Nevertheless, I attempt to decolonize my research process by whose voices I choose to amplify and some ethical considerations. The third layer is my attempt to practise refusal and resistance within the Westernized field of language policy and planning by applying decolonial perspectives to its frameworks. The complex dynamic produced by the interaction of these layers is present throughout this thesis.

In the next chapter, I present existing research on language barriers in health care and then introduce my conceptual framework.

CHAPTER 3: LITERATURE REVIEW

In this chapter, to argue in support of the potential role of the Inuit Language in the efficient provision of mental health services in Nunavut, I first present existing research on language barriers to health care and highlight challenges faced by both patients and providers when the system in place has not been designed for non-Western languages and cultures. I then outline the main concepts of this thesis, which include language policy and planning, linguistic imperialism, and decolonization. Lastly, I briefly review the literature on the decolonization of mental health services by way of language, mentioning the existing model for such services in Nunavut.

3.1 Language barriers to health care

Language not only contributes to how well a patient can express themselves, but also to how well their practitioner understands them, and how well the institutions promote their services in the patient's dominant language—all of which are interrelated. Firstly, language barriers can affect access to adequate care, cause underutilization of services and thus lead to poor health outcomes in patients. Secondly, language can be a barrier to communication where patients are unable to adequately express themselves and conceptualize mental health and wellness in the dominant language. Thirdly, language can affect the quality of service delivery and whether a provider is able to properly assess and accurately diagnose their patient. Their understanding of the patient's expressed condition will dictate the elected course of treatment. Research on those three types of barriers is presented in the sections below.

3.1.1 Language barriers to accessing health care

Literature regarding language and access to essential health services, including mental health, has largely focused on serving growing immigrant populations and institutional shortcomings in the provision of health care services on the whole (Bowen, 2015; Leis et al., 2013). In short, this

research concludes that requesting service in a minority language, regardless of its official status, is often associated with reduced access to services, longer wait times and, ultimately, poorer health outcomes (Bowen, 2001).

Access implies more than just service availability. It also refers to knowledge of existing services on the part of the patient, participation in the services and access to information about the services (i.e., how the services may be beneficial) (Bowen, 2015). Language barriers can affect each of these areas, right from initial service access involving telephone systems, answering machines, intake forms, and screening protocol (Bowen, 2001). Differences in access based on language and culture are perhaps even better observed in countries with universal health care like Canada, where socioeconomic status is much less of a variable than in countries with private health care, such as the United States (Brisset et al., 2013).

The issue of access to health care in one's first language is well known to Canada's Francophone minority population, who have constitutional as well as federally and provincially legislated rights to essential services in French, as one of the country's official languages. A famous example of the assertion of these rights is known as SOS Montfort (or the Montfort Affair). In 1997, after the Ontario government announced that it would be closing Montfort Hospital in Ottawa, the SOS Montfort coalition mobilized some 10,000 Franco-Ontarians in a rally to protest the closure. The fight to maintain rights to health services in French culminated in Ontario courts ruling in favour of upholding the constitutional rights of this Francophone minority community (Gagnon, 2017). Today, while Francophone minority communities have access to health services in French according to provincial policies, in practice, barriers to access are an ongoing concern. Forgues et al. (2017) found that in four provinces, factors affecting the provision of services in French

included the willingness of hospital administration to ensure them, lack of French-speaking staff and pressure of Anglo-dominant environments.

In Nunavut's specific situation, the 2015 report following a systemic investigation of the provision of primary care services in the Inuit and French languages at Qikitani General Hospital (Office of the Languages Commissioner of Nunavut, 2015) found that language barriers to access pertained, among other factors, to the availability of interpreters outside of regular business hours. This means that a monolingual Inuktitut speaker would not be able to properly communicate with staff on evenings, weeknights or weekends unless someone was around to interpret in an unofficial capacity. Among its conclusions, the report stated that "Inuit and Francophone patients do not benefit from the same health care ethical standards as English patients" (p. 30).

A 2021 report by ITK on Systemic Discrimination in the Provision of Health care in Inuit Nunangat[2] notes that the transient nature of availability of health professionals in Inuit regions make it that they are often not familiar with Inuit culture and do not speak the language. The report specifically highlights "systemic discrimination on the basis of language" as a barrier to accessing care as:

> Inuit too often struggle to communicate with health care providers because the majority of Inuit speak Inuktut as our first, only or preferred language, yet most frontline health professionals are non-Inuit and do not speak Inuktut. Furthermore, the availability of interpreters can be inconsistent, forcing patients in some cases to rely on friends and family members to interpret for them. (p. 3)

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[2] Inuit Nunangat refers the four Inuit regions in Canada, home to 51 communities: Inuvialuit (northern Northwest Territories), Nunavut, Nunavik (northern Quebec) and Nunatsiavut (northern Labrador). (ITK, 2021)

Beyond service availability, research has also explored whether there is a correlation between proficiency in a dominant language (most often English) and utilization rates or probability of utilization of mental health services (Ohtani et al., 2015). Some studies have found that among immigrant groups, individuals with lower proficiency were less likely to seek the services they needed (Chen et al., 2009; Kim et al., 2011; Sentell et al., 2007). Further, among certain immigrant populations, lower proficiency in the dominant language was associated with a more negative perception of seeking alternative care such as mental health services (Ohtani et al., 2015).

Limited proficiency in a dominant language has also been associated with less participation in preventative care activities and an underutilization of promotional or educational health resources (Bowen, 2015). This also extends to limited opportunities to participate in clinical trials and thus less access to newer treatments. Clinical trials with limited population diversity may also prove less applicable to patients on the whole (Bowen, 2015). This importance of access to health promotion and prevention in one's own language is also highlighted in the Final Report of the Office of the Languages Commissioner of Nunavut (2015) on Qikitani General Hospital.

3.1.2 Language barriers to communication in therapeutic interventions

As Kyoon et al. (2018) put it, "language is a key determinant of wellness because it affords the deeper expression of thought and action that influence beliefs and practices such that the health care providers and patients need a common understanding of concepts in order to arrive at accurate diagnosis and treatment thereafter" (p. 688). In other words, language is the main vehicle through which a connection can be established between a patient and provider. That said, this depth of understanding can be affected where a patient is expressing themselves in a second or third language, or their expression is being conveyed by an interpreter.

This has been observed in therapeutic interventions such as narrative therapy, where patients who have experienced some form of trauma are asked to "recall and recount traumatic memories in an effort to desensitize clients to the adverse effects of the traumatic event (Halligan et al., 2002; Schauer et al., 2005)" (cited in Bailey et al., 2020, p. 153). Patients have been found to illicit less emotional responses when recounting events in their non-native language or in a language other than the one in which the event transpired. Since the goal of narrative therapy is to expose patients to the same emotional responses they would have experienced during the event to increase their threshold, reduced emotional responses brought on by the language of treatment could potentially weaken the effectiveness of the intervention. Bailey et al. (2020) explain as follows:

> […] the increased cognitive complexity associated with processing information in one's non-native language can divert attention away from the substance of discourse, toward affectively empty language categories, such as grammatical aspects of speech (e.g., verb conjugations, article usage, etc.) and word categories (e.g., space and motion), allowing for a more subtle form of cognitive emotional avoidance. (p. 159)

Both patients and providers have indicated that the concepts and terminology afforded by Western medicine do not always translate to non-Western languages and cultures—and the reverse is also true (Arafat, 2015; Bailey et al., 2020; Granek et al., 2020; Kyoon-Achan, 2018; Romain, 2017; Woodward et al., 2020). The lack of equivalence in other cultures has even made it difficult to help patients grasp the importance or benefits of therapy (Arafat, 2015; Woodward et al., 2020).

Differences in the conceptualization of mental health and wellness, and language as the instrument used to express these depths, can be especially observed in Indigenous cultures. Schmidt (2019) highlights this complexity when recounting her time as a non-Indigenous professor of psychology in Sydney, Nova Scotia, on the traditional and unceded territory of the Mi'kmaq / L'nu nation. She

explains that “neither Eurocentric culture nor the English language are universal, objective or representative of the majority of people in the world” (p. 68). For instance, the Mi’kmaw language has aspects that do not exist at all in English, such as a Healing verb tense and a Spiritual verb tense.

Dana-Sacco (2012) argues that “It is in the act of translation that a subtle and pervasive extension of the colonization process occurs” (p. 7). Indigenous languages are generally centred around the expression of interrelationships while English tends toward individualistic constructions. Translations toward English thus compromise these interrelationships, deconstructing complex verb forms and approximating them in English (Dana-Sacco, 2012). One example of this is the complexity of the health ideology in Indigenous cultures versus its meaning in English. Inuit health and well-being is rooted in *Inuit Qaujimajatuqangit* (*IQ*), which “encompasses the entire realm of Inuit experience in the world and the values, principles, beliefs and skills which have evolved as a result of that experience” (Tagalik, 2010, p. 2). *IQ* is accompanied by a host of concepts in Inuktitut that require deep thinking and contextual understanding to fully grasp, such as *aajiiqatiniiniq*, meaning the process of coming back into balance. “There are elements of language which are uniquely situated in culture and cannot be translated into another language without loss of meaning” (Tagalik, 2010, p. 6).

Some Australian studies (Biddle & Swee, 2012; Sivak et al., 2019) also demonstrate that the very act of being able to express oneself in one’s own language can have a positive impact on mood and general well-being. Participants associated being able to learn and/or speak their Indigenous language, with feelings of happiness, belonging, empowerment and pride:

> Unique protective factors contained within Indigenous cultures and communities have been sources of strength and healing when the effects of colonization and oppressive legislation

> have resulted in loss, grief, and trauma. Language remains one of these foundational protective factors which may provide novel solutions to support communities to grow, survive, and thrive. (Sivak et al., 2019, p. 14).

Pertaining to the Inuit Language, Newell et al. (2020) caution against seeing this relationship between language and well-being at a superficial level, where simply providing services in Inuktitut or Inuinnaqtun would be culturally appropriate. Body language and silence are integral parts of Inuit communication:

> While some Inuit are not verbally expressive, they may express themselves using facial expressions, body language, and indirect requests. Some Inuit patients may thus be communicating what they feel without verbalizing. (Moller, 2016, p. 96)

Unawareness of these aspects of communication on the part of mental health care practitioners and interpreters could have significant impact right from intake to the treatment prescribed, to whether the treatment is effective. Language's "inseparable yet multidimensional" (Sivak et al., 2019, p. 13) impact on well-being reinforces the need for holistic and culturally aware service provision policies to effectively impact communities in need.

3.1.3 Language barriers to effective service delivery

Language barriers can not only affect a patient's ability to communicate with their mental health provider, but also the provider's ability to fully grasp what their patient is expressing and, ultimately, prescribe and/or provide them with as well as communicate suitable and effective treatment.

These issues are noted in studies assessing the effect of language when using script- or story-based interventions (which are inherently linguistic) when examining internal working models of

attachment in adolescents and adults (Venta et al., 2017). The authors explain that "attachment interviews are linguistically burdensome by design" (p. 815), which in turn means that the added difficulty of assessing patients in their non-native language could affect the accuracy of the assessment where the provider has difficulty capturing nuanced expressions, and the content disclosed is influenced by the patient's second language. As with other studies, the authors make a point of mentioning that where there is language, there is also the presence of culture:

> […] it bears mentioning that there have long been concerns that the measurement of attachment is biased against non-Western cultures and that measures developed in the United States and Western Europe would overclassify other ethnic groups as insecurely attached. (Venta et al., 2017, p. 825)

The importance of language has also been demonstrated in assessing mental distress and suicidality in patients. Providers have been found to lack awareness of nuanced messages and expressions of distress, leading to unsuitable or ineffective treatment for their patients (Arafat, 2015).

> Various factors such as pain, vulnerability or stress sometimes result in having a patient who has a good command of Inuktitut and English, or French and English, to lose the ability to clearly express themselves in their second language under certain circumstances. In that case, the patient is becoming unable to understand health care professionals or make themselves understood. (Office of the Languages Commissioner NU, 2015, p. 35)

In a recent study on cultural facilitators and barriers to communication about mental health distress and suicidality of cancer patients, conducted in Israel, Granek et al. (2020) identify language competency—that is the provider's competency in the patient's L1 and the patient's ability as a non-native speaker of the dominant language—as a two-fold barrier. First, where oncologists do

not speak the patient's L1, it limits their ability to assess the degree of suicidal thoughts in their patients and detect nuances that the patients may be using to express their distress. Second, it inhibits the practitioner's ability to observe complex interactions between language and culture during discussions with patients. Health care practitioners have also emphasized that even with patients who speak the dominant language, cultural competency was still needed to properly interact with patients.

> If you cannot communicate with your patient, your patient is not safe. Being able to speak in one's mother tongue when it concerns health is not asking a favour of health care professionals or organizations. On the contrary, it is a basic issue of accessibility, safety, quality and equality of services. (Office of the Languages Commissioner NU, 2015, p. 2)

To improve patient-provider interactions, institutions have adopted two main avenues of solution: culture and language matching; and using interpreters. In the case of the first strategy, providers have indicated that the understanding or sharing of cultural norms and language facilitates communication with their patients (Granek et al., 2020). This can also influence attendance, where:

> […] substantial evidence suggests that ethnic and language match between therapist and client is associated with longer therapy attendance and lower treatment drop out among multiple ethnic minority groups, although results have been mixed with small effect sizes, limitations in study sampling and methodologies, and difficulties in isolating the effects of ethnic versus language match (Ibaraki & Nagayama Hall, 2014; Karlsson, 2005; Maramba & Nagayama Hall, 2002; Shin et al., 2005). (cited in Chu et al., 2016, pp. 20-21)

In fact, researchers have inquired whether language-matching or culture-matching alone is sufficient for effective mental health provision, or both need to be present to yield the best results.

In this line of thinking, Granek et al. (2020) suggest *cultural humility* to remedy issues pertaining to power dynamics between health care provider and patient. Social power in health care provision can be two-fold in that: 1) the patient-provider relationship already implies a hierarchy where the provider is presumed to hold the knowledge and expertise; and 2) a second layer of hierarchy can be observed in cases where the provider belongs to a privileged or majority group and the patient to a minority or marginalized group (Granek et al., 2020). Hence, the *cultural humility* approach is "guided by values that promote diversity and equity, while being attentive to structures of power and hierarchy in cross-cultural interactions" (Granek et al., 2020, p. 244) where

> Conducting open conversation in a cross-cultural encounter additionally requires raising awareness and promoting knowledge about mental health needs and care preferences including communication styles. (*idem,* p. 225)

The second avenue of solution to improve patient-provider interactions is a widely documented recourse to professional and ad hoc interpreters. For instance, in Canada, some service providers have pointed out that a common misconception with regard to Francophone minorities is that if a patient speaks some English, they do not require an interpreter or a language-matched health professional. However, as research shows, this can lead to misinformation, misdiagnosis, and failure to obtain appropriate patient consent (Bowen, 2015).

Further, in a study by Brisset et al. (2013), primary care mental health practitioners in Montreal reported that accessing Allophone clients' emotions and show empathy toward them by way of an interpreter was very challenging. Using interpreters as a solution introduces a series of other concerns including the interpreter's knowledge of the mental health field, the interpreter's ability to accurately convey empathy while maintaining neutrality and their ability to translate

sociocultural information (Brisset et al., 2013). Common reported problems related to interpreting are omission, addition, condensation, substitution, normalization and alteration, as "the ability to speak the language does not necessarily imply having the skills to convey the exact sameness of meaning," (Arafat, 2015, p. 72) thereby leaving room for inappropriate intervention.

Mental health is the area in which health care practitioners have the most concerns about using interpretation services, namely confidentiality (Arafat 2015; Tribe & Lane, 2009; Wohler & Dantas, 2017). Some patients are less likely to disclose accurate or entirely truthful information because they do not want the family member interpreting for them to know or for fear of being judged. Hence, having done extensive research in the area of language barriers in Canada's health care system, Bowen (2001; 2015) emphasizes the advantages of language congruence (or matching), which implies a comfortable level of language ability on both the part of the provider and the patient, to avoid interpretation risks where possible.

The literature I have presented demonstrates incongruities brought on by mental health services that were not designed for their specific beneficiaries. A few authors connect language barriers in health care or mental health to a pervasion of colonialism, where patients are required to operate within Westernized spaces to receive care and often make concessions which can ultimately affect the quality of service they receive. Should they choose or be unable to operate in this space—i.e., lacking proficiency in the language and communicative norms of the provider—the consequence becomes reduced access to service or no service at all. If patients in need are unable to access or benefit from mental health services due to linguistic and cultural incongruities, then this means that the services were not designed to help them, or that help is conditional upon them adhering to the dominant language and norms. Thus, for mental health services to help Inuit, they should be designed for Inuit, and this requires consideration for language. To examine the ways this can be

achieved, in the next section, I discuss conceptual frameworks that show how colonialism has used language as a vehicle of dominance, and what various Indigenous and non-Indigenous scholars make of this with regard to language policy and planning, especially in the domain of health care provision.

3.2 Conceptual framework: Beyond Western perspectives on well-being

In this section, I first introduce the concept of language policy and planning (LPP), which is essential to understanding language policy in Nunavut in relation to mental health services and supports. Second, I present several research perspectives on the effects of colonization on language, including concepts of linguistic imperialism, linguicide, language hierarchy, and multilingualism. Although these concepts were not developed for the mental health domain, I will show that they can be used to look at language as an indicator and vehicle of colonial norms in the provision of mental health services to Inuit. I will then define the concept of decolonization and describe the decolonial lens adopted in my study.

3.2.1 Understanding the Inuit Language from an LPP perspective

Language policy and planning (LPP) is a field of applied linguistics that took form in the 1960s when researchers became interested in solving language problems in post- or neocolonial contexts (Johnson & Ricento, 2013). LPP is applied by researchers (Hornberger, 2009; McCarthy, 2013; Tulloch et al., 2018) to a variety of domains and often addressing Indigenous, minority and heritage languages. Spolsky (2012) defines language policy as having “three inter-related but interdependent components” (p. 5): language practices among the community of speakers, including varieties and variants; the values attributed to the varieties and variants; and where the authority to manage the language and its practices lies. As a conceptual framework, LPP seeks to investigate:

> the processes by which languages and language varieties obtain particular statuses in various domains of private and public life, and how policies (whether explicit or implicit) reaffirm or attempt to modify in some way such achieved or ascribed statuses of languages. (Ricento, 2008, p. 212)

LPP can involve three processes: status planning, corpus planning, and acquisition planning. Early uses and definitions of the terms status planning and corpus planning are found in studies by Haugen (1959) and Kloss (1969) (in Johnson & Ricento, 2013). Acquisition planning was established years later by Cooper (1989) to "capture language teaching and other education activities designed to increase the users or uses of a language" (in Johnson & Ricento, 2013, p 11). Modern definitions of these concepts were then developed by researchers such as Ricento & Hornberger (1996) who explain that "Status planning concerns uses of language, acquisition planning concerns users of language, and corpus planning deals with language itself" (p. 402). Status planning thus involves the establishment of explicit (laws) or implicit (e.g., within a family) language policies. Where status planning can be observed at various levels of society, acquisition planning often focuses on language-in-education policies as well as language promotion and language revitalization policies (Tulloch et al., 2018). Corpus planning also pertains to these same areas. All three processes are interrelated and can serve to highlight the state of a language or relationships between multiple languages within a given social or political landscape.

LPP can be used to examine not only types of language planning (corpus, status and acquisition) and policy (de jure or de facto), but also the processes by which policies are created, and the scales on which they are practised (e.g., national, regional, family) (Johnson & Ricento, 2013). It is true that LPP is a Western concept that stemmed from a need to address problems created by colonialism and linguicide, and new realities created by diversified and globalized societies.

However, it has also been frequently applied to Indigenous contexts, like decolonizing education, where it can be considered "symptomatic of and embedded in the broader processes of colonization and decolonization, as well as a tool for rebalancing power and relationships in the neocolonial context (Battiste, 2013)" (cited in Tulloch et al., 2018, p. 241).

In this thesis, I use decolonizing perspectives to examine language policies and planning of mental health service providers serving Nunavut in relation to the Inuit Language, which has official status and is the dominant language of 76.6% of Inuit in Nunavut (Lepage, Langlois & Turcotte, 2019).

In the next section, I introduce concepts which fall within the realm of LPP aiming more specifically at colonization/decolonization processes, namely linguistic imperialism and linguicide. I also present the various perspectives of authors who contribute to the LPP research in this realm.

3.2.2 Colonialism, linguistic imperialism and linguicide

Linguistic imperialism can be considered a form of linguicism. Linguicism refers to "ideologies, structures and practices which are used to legitimate, effectuate, regulate and reproduce an unequal division of power and resources (both material and immaterial) between groups which are defined on the basis of language" (Skutnabb-Kangas, 1988, p. 13). Linguistic imperialism is a concept that helps explain "how and why certain languages dominate internationally, and attempts to account for such dominance in a theoretically informed way" (Phillipson and Skutnabb-Kangas, 2013, p. 495). English linguistic imperialism can be directly associated with British colonization, to which Canada, now a Commonwealth country, was subject.

Phillipson (2010) has built a theory of linguistic imperialism and written extensively on mechanisms which allow for the establishment a hierarchy of languages in all areas of society,

both structural and ideological. His research helps to understand how dominance of certain languages was established as normal by reinforcing glorifying beliefs and attitudes around them while stigmatizing others. According to the linguistic imperialism theory, rights, resources, and privileges are disproportionately accorded to speakers of dominant and non-dominant languages in both law and education (Phillipson, 2010). Hierarchical relationships between languages can be maintained through the following pattern:

> *stigmatization* of dominated languages (mere 'dialects,' 'vernaculars,' 'patois'), *glorification* of the dominant language (its superior clarity, richer vocabulary), and *rationalization* of the relationship between the languages, always to the benefit of the dominant one (access to the superior culture and 'progress'). (Phillipson & Skutnabb-Kangas, 2012, p. 500)

Where Phillipson demonstrates why certain languages dominate society, Skutnabb-Kangas (2000) explains that this dominance comes at the expense of other languages, and that the price to pay is most often extreme endangerment, if not extinction. According to this author, the vitality of a language can be assessed based on three factors: the number of speakers; whether the language is passed down with each generation; and policy. Similarly, there are three ways in which a language can be eliminated: 1) physical genocide; 2) linguistic genocide; and 3) rendering invisible (Skutnabb-Kangas, 2000). Linguistic genocide refers to actively "killing a language without killing the speakers" (p. 312) or passively letting it die. One of the primary vehicles of linguicide is assimilationist education policies whereby children are educated solely in the language of the people in power and forbidden to use their minority or Indigenous language. This was the case for Finnish and Sami in Sweden, from 1888 to 1957, Māori in New Zealand, and the majority of Indigenous languages of African and Latin American colonies (Skutnabb-Kangas, 2000). Canada

is, of course, no exception. The Indian Residential School System, which I briefly described earlier, running from the 1800s to 1996 by the Government of Canada and the Catholic church, is the quintessential example of linguicide by way of assimilationist policy. Although there was no explicit language policy governing residential school system, the implicit policy was English only. This subtractive approach was enforced violently and punitively in many cases (Griffith, 2017).

Phillipson and Skutnabb-Kangas (2012) make the case that there is a connection between linguistic imperialism and linguicide. They argue that:

> to analyze the reasons for languages being maintained, marginalized, or murdered (Skutnabb-Kangas and Phillipson, 2010) requires a situated framework which sees language in the historical, economic, and political context of 'globalization' (cited in Phillipson and Skutnabb-Kangas, 2012, p. 507).

For these authors, that conceptual framework is linguistic neoimperialism.

Other authors (Blommaert, 2010; Fishman, 2011; May, 2014; Pennycook, 2016), however, draw alternative conclusions, and some even criticize this view. They start from the notion that English is the *lingua franca* and examine language rights and justice through the lens of globalization and multilingualism. Fishman (2011) describes the terms "imperialism" and "neo-colonialism" as "slippery slopes". He claims that:

> "imperialism" denotes the exploitation of a colony for the benefit of an occupying power. "Neo-colonialism" denotes the continuation of the aforementioned exploitation even after the occupation has ended. Both terms are handicapped by the fact that "exploitation" is a perspectival or judgmental term that leaves behind it the quandary of how to label the large

> number of cases in which colonies are not (or are no longer) beneficial to the occupying powers and when, therefore, the latter may be said to be exploited by the former, rather than the other way around. (p. 5)

In other words, colonialism and imperialism are realities of the past, and the modern-day dominance of a language such as English may not always mean the persistence of imperialism but perhaps the existence of multinationalism. Fishman (2011) suggests reconceptualizing English in particular, whereby it "may well be the *lingua franca* of capitalist exploitation without being the vehicle of imperialism or even neo-imperialism *per se*" (p. 8).

Pennycook, also a critic of Phillipson, examines the relationship between the English language and power through a post-modern, sociolinguistic lens. Pennycook (2016) does not debate the idea that one must be aware of the connections that English has to colonial exploitation and present-day inequalities, however, where the two authors diverge concerns how to go about reconciling the past.

> The equation of a linguistic imperialism thesis with a critical standpoint, and the frequent dismissal of this totalizing version of events on the grounds that it overstates the case, draws attention away from the necessity to evaluate the global spread of English, and the role of English language teachers as its agents, critically and carefully. (Pennycook, 2016, p. 29)

Like Fishman, Pennycook (2016) maintains that linguistic imperialism is too narrow a scope of study and that instead of resisting the pervasive presence of English, we should be focusing on levelling the playing field for learners and speakers of World Englishes through better pedagogical

practices and discern where English can be to the advantage of society. He notes that it is not about:

> whether some monolithic thing called English is imperialistic or an escape from poverty, nor how many varieties there may be of this thing called English, but rather what kind of mobilizations underlie acts of English use or learning? (Pennycook 2016, p. 32)

While no scholars negate the everlasting impacts of colonialism or the use of language as one of its prime vehicles, there is a certain acceptance of the past by some researchers (Fishman, 2011; May, 2014; Blommaert, 2010; Pennycook, 2016) which determines the lens through which they examine the present as well as solutions for the future. Colonial languages are not rejected, but rather embraced. For example, May (2014) makes a case for how multilingualism at both the individual and state levels can provide “greater opportunities for linguistic justice” (p. 373) and social mobility. Both Pennycook (2016) and Blommaert (2010) discuss how access to the dominant language is stratified in society through access to learning and standards of quality. Blommaert (2010) examines how English and French are taught and expressed around the world as a result of globalization and contends that a variety of registers or varieties should be accepted by dominant societies such as North America and the United Kingdom.

Regardless of their preferred conceptual frameworks, Canadian scholars, both Indigenous and non-Indigenous, have the same starting point: the historic and present impact of colonization on Indigenous languages. Though the colonial destruction of Indigenous languages is referred to as “history” and “past” in Canada, it is all too recent. So recent, in fact, that the Canadian government’s efforts to officially make amends for its part in the destruction began only in 2008

and the term “reconciliation” only became a political consideration in 2015 with the publication of Final Report of the Truth and Reconciliation Commission (2015).

In this context, a critical review of recent mental health research done by Nelson and Wilson (2017) identifies the impacts and legacy of colonialism as main subjects in the articles reviewed. Moreover, according to the authors:

> More research is needed which continues to take into account the impacts of colonialism, and critically examines the history of mental health research in Canada so as to avoid following patterns rooted in colonial stereotypes. (p. 103)

In the same vein, Griffith (2017) directly refers to Phillipson’s linguistic imperialism in an article about the role of English in Canada’s Indian residential schools:

> The language policies and practices of settler colonial schools for Indigenous children in Canada participated in what Robert Phillipson calls "linguistic imperialism": when language denigration coincides with other forms of oppression yet appears (to settlers) as natural and legitimate. If language denigration becomes language death, scholars such as Phillipson, Tove Skutnabb-Kangas, and Andrea Bear Nicholas refer to the term “linguicide” – killing a language but not necessarily the speaker. (pp. 764-765)

Fontaine (2017) directly links Indigenous language rights in Canada to the legacy of the Indian Residential Schools, assimilationist legislation like the *Indian Act*, and exclusionary legislation like the Constitution (1982). This author maintains that just as the Canadian government stripped Indigenous peoples of their languages by way of education, policy, and legislation, it is by those very same means that it can help revitalize these languages:

> Still, in spite of the detrimental role education policy and institutions have had on Indigenous cultures, the reality is that they now have a critical role to play in the revitalization of Indigenous languages (Fontaine, 2017, p. 184).

Fellner (2018) makes the following direct link between colonialism and Indigenous wellness:

> Colonial ideologies pervade case conceptualization, assessment, diagnosis, and interventions, and promote potentially damaging patronizing attitudes toward Indigenous peoples and approaches to wellness, power discrepancies in the therapeutic relationship, and other oppressive mechanisms embedded in Western Eurosettler frameworks (Fellner, 2016). (cited in Fellner, 2018, p. 286)

Haque and Patrick (2015) demonstrate the significant role that official and unofficial language policy played in decimating Indigenous languages in favour of settler languages. They conclude the following:

> Only by recognizing how language policies operate to embed and reinscribe the racial hierarchies at the heart of Canada's ongoing national project can we begin to decolonize the exclusion of indigenous languages, cultures, and peoples in Canada. (p. 39)

Indeed, the conversation in Indigenous language research in Canada has been shifting from impacts of colonialism on language and culture to the potential of decolonizing approaches to methodology, language policy, planning, revitalization and pedagogy. In the field of language revitalization, McIvor (2020) acknowledges:

> One foundational orientation for the field of ILR is that of decolonization theory defined by its overt acknowledgment of historic injustices, followed by support for the resurgence

> of Indigenous knowledge and ways of being (Battiste, 2013 ; Gaudry, 2015; Simpson, 2011). (pp. 78-79)

Naturally, there are differences in how and where decolonizing perspectives and approaches are applied to research. When referring to "decolonizing politics," Patrick (2019) puts forth the notion of *coexistence,* whereby:

> Examining how Indigenous ways of speaking and knowing can mesh with Western (settler) ways within Inuit and other Indigenous-run school boards or local governance structures remains an important direction in local, regional, and national Indigenous language politics. (p. 256)

This research project aligns with this shift toward decolonization in the field. As I move toward introducing decoloniality as my conceptual framework, it is worth noting the pattern in citation practices among the authors whom I cited in this section. All, whether European, Canadian, Indigenous or non-Indigenous, have a tendency to limit their literature references to specific Western researcher names in their field (e.g., Kathleen Heugh, Carol Benson, Michael Krauss, Nancy Hornberger, Teresa McCarty, etc.). Similarly, references to research on decolonization are most often limited to Tuck & Yang (2012), Smith (1999), and Battiste (2013). Their important contributions notwithstanding, I will demonstrate from here on that there are also other non-western research perspectives, many informed by lived experience, that can enrich our understanding of coloniality and decoloniality as they pertain to language and mental health.

In sum, in this section, I discussed various conceptual frameworks that are used to examine how relationships between language and power produce policies in favour of a dominant culture in colonial and neocolonial contexts. I painted a picture of how Western researchers address how to

remedy colonial legacy while operating within Western paradigms. In Canada, both Indigenous and non-Indigenous researchers (myself included) operate within the confines of knowledge as defined by the settler academy, which itself has faced calls to decolonize its practices (e.g., Datta, 2018; Fellner, 2018; ITK, 2018; Morgensen, 2012).

In the next section, I show how some non-Western researchers propose engaging in decolonial practices within settler spaces. I also present decolonization as my conceptual framework for examining the relationship between language and mental health services.

3.2.3 Decolonizing perspectives

Martinique psychiatrist and philosopher Frantz Fanon was among the first scholars to call for the researchers "to articulate alternative understandings that were more conducive to human liberation" (Adams et al., 2017, p. 214) and is known as one of the originators of decolonization theory. In his book, *The Wretched of the Earth* (published in French in 1961 and in English in 1963), famously prefaced by Jean-Paul Sartre, Fanon describes the workings of colonialism, colonists, the colonized, and those who seek to decolonize. He submits that, just as colonization was violent, so must be decolonization. However, Fanon (1963) does not prescribe what decolonization should look like. He states that "any decolonization is a success" (p. 2) and explains that "because decolonization comes in many shapes, reason wavers and abstains from declaring what is a true decolonization and what is not" (p. 21).

To understand decolonization and decoloniality, it is necessary first to understand the concept of coloniality. Latin American scholar Nelson Maldonado-Torres (2007) describes coloniality as:

> long-standing patterns of power that emerged as a rule of colonialism, but that define culture, labor, intersubjective relations, and knowledge production well beyond the strict limits of colonial administrations. (p. 243)

This means that coloniality exists beyond and apart from colonialism as an integral part of the post-colonial world. Maldonado-Torres refers to this as the *coloniality of being*.

Sunil Bhatia (2020), who writes on decolonizing psychology in India, breaks down the nuances of decoloniality, and decolonizing as follows:

> Decoloniality, while closely connected to the concept of decolonization, involves understanding how "coloniality" as an overarching framework continues to reflect the current power relations (…) Decolonization thus involves understanding and documenting the process of colonization and how it impacts people in the past and present (…) Decolonizing means disrupting the traditional research process (…). (p. 258)

There are many other definitions of decolonization (e.g., Datta, 2018; Fellner, 2018; Sium, Desai & Ritskes, 2012; Smith, 1999; Tuck & Yang, 2012;) and what decolonial approaches to mental health should involve (e.g., Adams et al., 2017; Lewis et al., 2018; Nelson, 2012; Schmidt, 2019; Trout et al., 2018). Nevertheless, concepts such as *undoing*, *reclaiming* and *revitalizing* can be seen throughout. Fellner (2018) puts it succinctly: "Decolonizing is a verb. It is an active, intentional, moment-to-moment process that involves critically undoing colonial ways of knowing, being, and doing" (p. 284).

Adams et al. (2017) demonstrate that scholars have been applying decolonial theory to psychology and language well beyond Europe and North America. For instance, in Latin America, Maldonado-Torres (2007) expands upon the *coloniality of being*. Kenyan scholar Ngũgĩ wa Thiong'o (1992)

published preeminent works on *decolonizing the mind*. He provided insights on practices of resistance (e.g., not writing in colonial languages) and decolonizing one's thoughts.

Thiong'o's earliest published works connecting language to colonialism and neocolonialism date back to the 1980s. He describes the process of colonization through language as follows:

> It starts with a deliberate disassociation of the language of conceptualization, of thinking, of formal education, of mental development, from the language of daily interaction in the home and in the community. It is like separating the mind from the body so that they are occupying two unrelated linguistic spheres in the same person. On a larger social scale, it is like producing a society of bodiless heads and headless bodies. (Thiong'o, 1998, p. 103)

The author refers to this experience as *colonial alienation*.

The field of psychology, and by extension mental health provision in Western cultures, is based in colonial systems. As Lewis, Hartwell, and Mhyra (2018) state, "[…] mental health professionals belong to a Western paradigm of knowledge and healing, and as members of this dominant paradigm, have the power to intentionally or unwittingly reject or devalue beliefs outside of the Western paradigm" (p. 331). Bhatia (2020) also notes that Eurocentric psychology "largely privileges experimental positivist methods, languages, symbols and stories" (p. 258).

Regardless of the postcolonial context, research emphasizes the importance of resisting and breaking away from the Western paradigm which promotes individualistic ways of being, to effectively administer services. Fellner (2018) describes it as a process involving deconstructing (decolonizing) and reconstructing (indigenizing). *Indigenizing* involves not only applying Indigenous traditions, knowledge and ways of being to services (Fellner, 2018), but also

empowering Indigenous peoples to shape their own health and well-being (Trout et al., 2018). Adams et al. (2017) note that:

> The particular strength of indigenization approaches to decolonization is the valorization of local understandings as a source of time-tested wisdom that is adapted to local conditions and well suited to the needs of local communities. (p. 224)

In other words, as research shows, Indigenous communities know best what they need for their healing and well-being. We will see in the next section that language is essential to indigenizing mental health services and supports in the case of Inuit.

3.2.4 Indigenous wellness models and language

First Nations, Inuit and Métis in Canada have holistic notions of health and wellness which are grounded in culture and based on the realities and needs of their people. For example, Métis Centre at the National Aboriginal Health Organization proposes self-determination, resiliency, healing, resurgence and education as the social determinants of Métis health. First Nations and Inuit have national-scale health and wellness models in which they acknowledge language as playing a role in mental wellness. The First Nations Mental Wellness Continuum, developed by the Assembly of First Nations, Thunderbird Partnership Foundation, First Peoples Wellness Circle, and First Nations & Inuit Health Branch (2015), is a multilayered and comprehensive framework grounded in a four directions model that balances body, mind, heart, and spirit. The framework includes culture as a social determinant of health, within which language plays an important role.

Inuit "are unique in their geographical location, culture language and history, including their distinct relationship with the Canadian government" (Newell et al., 2020, p. 64). They have their own cultural (or traditional) knowledge and practices called *Inuit Qaujimajatuqangit* (*IQ*), which

is directly linked to how they define well-being. Language is an integral part of this definition. In 2014, Inuit Tapiriit Kanatami (ITK) published a document establishing social determinants of Inuit health in Canada, which differ from the social determinants of health identified by the World Health Organization (WHO), and by the Canadian government. The WHO defines social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system" (WHO, 2020). For its part, Canada has 14 social determinants of health, which refer to social exclusion, social safety, gender, race and Aboriginal Status (Raphael, 2010). While ITK's model (Figure 2) identifies mental wellness and safety as its social determinants, it is in fact more wholistic and closely connects its "culture and language" category to well-being (ITK, 2014). Moreover, in the Inuit context, one particular indicator of cultural well-being remains strong in many regions: the use of the Inuit Language (ITK, 2014, p. 14) which "is also often recognized as one of the most tangible symbols of culture and group identity (Blair, Rice, Wood, & Janvier, 2002; Norris, 1998), and the main vehicle for cultural transference (Norris & Jantzen, 2002; Royal Commission on Aboriginal Peoples, 1996)" (cited in McIvor et al., 2009, p. 12).

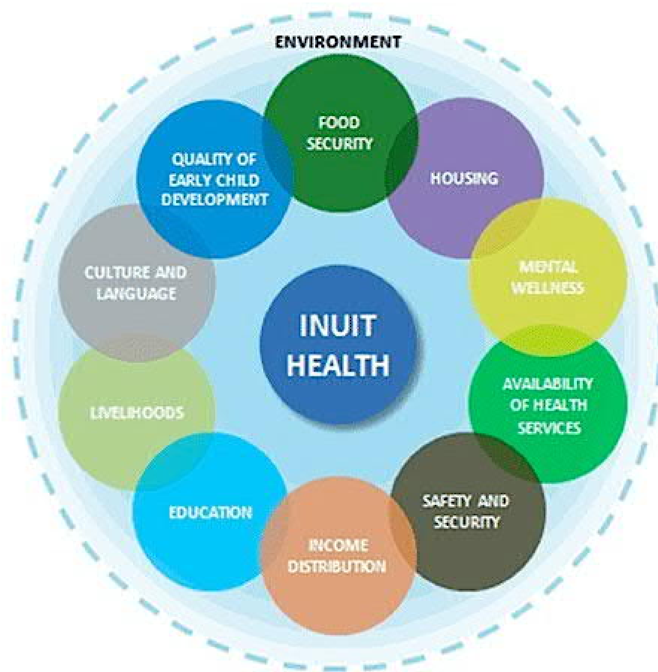

Figure 2: Social Determinants of Inuit Health (ITK, 2014)

This literature review demonstrates that providing mental health services to an Indigenous population without breaking away from its colonial history may not be the most effective, and that

just as language was instrumental in colonizing Canada and beyond, so it can be in decolonizing and indigenizing health care services. Hence, identifying how modern institutional language policies may perpetuate (or challenge) colonial norm is to begin decolonizing practices. Going beyond Western knowledge and approaches to mental health services is, in part, to decolonize them by way of language. It is for this reason that my project seeks to explore whether institutions serving the Inuit in Nunavut have taken steps to decolonize their services by way of the Inuit Language. In the next section, I explain the research method that I will use to answer my research questions for this study formulated in Chapter 2 of this thesis.

CHAPTER 4: METHODOLOGY

In this chapter, I first propose a decolonial approach to data collection and analysis as a basis for this project that takes the form of an exploratory qualitative study. Second, I outline my processes for collecting data from two sources, policy documents and semi-structured qualitative interviews with representatives of key mental health service providers in Nunavut. Third, I present the protocol for data analysis.

In the following section, I explain decoloniality as a methodological framework and how I applied it to my study.

4.1 Decolonizing methodological framework

Approaching my research from a decolonial perspective also extends to the methods I used to collect and analyze data. Decolonial theorists (e.g., Chilisa, 2012; Ndhlovu, 2021; Tuck and Yang, 2014) have indeed repeatedly characterized Westernized/Eurocentric research methodologies as rigid, invasive, and 'othering' practices, seeking to control and define knowledge, and assert power. Contrasting with Western methodological stances, Chilisa (2012) defines decolonizing research methodology as:

> a process that involves "researching back" to question how the disciplines—psychology, education, history, anthropology, sociology, or science—through an ideology of Othering have described and theorized about the colonized Other, and refused to let the colonized Other name and know from their frame of reference. (p. 14)

Othering can be defined as "the process whereby an individual or groups of people attribute negative characteristics to other individuals or groups of people that set them apart as presenting that which is opposite to them" (Rohleder, 2014, p. 1306). This can involve generalizations,

stereotyping, and prejudice, often causing irrational feelings of fear or hate toward said individual or group.

Maori anthropologist Linda Tuhiwai Smith provides thoughts in her book *Decolonizing Methodologies: Research and Indigenous Peoples* (1999), a foundational piece on rethinking research methodologies and practices through a decolonial lens. Smith did not originally intend for this book to have non-Indigenous readership, however it did just that, and more. In her 2012 introduction, she notes:

> The book has somehow reached and touched a hugely diverse range of scholars, from different disciplines and linguistic contexts. It has been a catalyst for re-examining curricula, revising some professional and ethical standards, and for capacity building and community empowerment projects. (p. xii)

Smith (1999) presents the idea of research as a sort of paradox, where the term is inherently imperialist and colonial, and yet its existence in Indigenous spaces appears inevitable. Her work therefore deconstructs Western scholarship and proposes decolonizing practices related to ethics, data sovereignty and community-based research.

Hence, as proposed by Smith, approaching my study from a decolonial standpoint required extensive thinking, rethinking, unlearning, and relearning what I have been taught about research and what I understand it to be. I therefore looked to the work of representative voices such as Smith (1999) and Fellner (2018) for guidance. Since my study primarily addresses the language policy practices of Westernized mental health service providers, I recognize that it is rooted in Western ways of knowing and doing. However, Fellner (2018) refers to the concept of "embodying decoloniality" which led me to believe that there were still choices that I could make throughout

my research process to contribute to the ongoing work of decolonizing and indigenizing. Embodying decoloniality implies "implementing Indigenous protocols and ethics" (Fellner, 2018, p. 291) and engaging with Indigenous ways of knowing and doing throughout this process. In a complementary way, Tuck and Yang (2014) refer to an analytical practice of "refusal," which they define as follows:

> Analytic practices of refusal involve an active resistance to trading in pain and humiliation, and supply a rationale for blocking the settler colonial gaze that wants those stories. Refusal can comprise a resistance to making someone or something the subject of research; it is a form of objectless analysis, an analytic practice with nothing and no one to code. (p. 812)

It is with this in mind that I elected to study the workings of policies instead of doing community-based or ethnographic research. While these approaches are invaluable in many contexts, from my position, Indigenous peoples in Canada are over-researched, overanalyzed, and over-consulted in Westernized ways. Indeed, most studies related to the provision of mental health services to Inuit are community-based or scoping reviews. However, when asking the question, "who/what needs to be decolonized?" perhaps the first answer ought to be: the institution. As Tuck and Yang (2014) put it, "Refusal turns the gaze back upon power, specifically the colonial modalities of knowing (…)." It is important to understand how people experience policy, but it is equally important to understand how policy is designed. If we do not understand how it is constructed, we cannot deconstruct, decolonize, and indigenize it.

There is no set of prescribed steps to decolonized research methodologies—they are non-linear by nature, the opposite of rigid. To establish a process for my own work, I asked myself a series of questions based on what I observed in the literature:

In what ways may my thinking about research methodology be too rigid, making me miss important information?

Which analytical framework(s) could allow for cross-cultural methods?

Which research authorities do I choose to cite on what subjects?

From which sources do I get my data?

What constitutes knowledge in the case of this study?

My thinking would be susceptible to rigidity in how I regard concepts such as research, ethics, and knowledge, based on my spheres of learning and socialization. I explored articles that address said concepts in the context of research involving Indigenous communities and/or policy. I read articles that specifically address decolonizing the Western academy (e.g., Fellner, 2018; Gaudry & Lorenz, 2018; Morgensen, 2012; Schmidt, 2019) and explored which frameworks were deemed appropriate in the literature (e.g., Riddell et al., 2017; Smith, 1999), in addition to accounts of lessons learned (Sarkar, 2017). There is consensus among researchers, both settler and Indigenous (e.g., Fellner, 2018; Riddell et al., 2017; Sarkar, 2017; Smith, 1999), that relationships of trust, respect, and acceptance are of the utmost importance in deconstructing colonial hierarchies and embodying decoloniality. When considering what would constitute knowledge in this study, I was deliberate in seeking out representative perspectives of how knowledge and ethics may be conceived by Inuit (ITK & NRI, 2007; Nickels & Knotsch, 2011; Tagalik, 2010; Tester & Irniq, 2008). Adams et al. (2017) describe a concept of "decolonization by indigenization," by which researchers seek to validate Indigenous concepts of health and well-being through strategies such as "*normalization*: treating as legitimate the Indigenous forms of knowledge and practice that mainstream science devalues or treats as illegitimate" (p. 224).

As mentioned in Chapter 1, Inuit have cultural knowledge, *Inuit Qaujimajatuqangit* (*IQ*), that guide all aspects of their life. This knowledge is also "embedded in process" (Tagalik, 2010, p. 2). It was important for me to reflect upon how these principles might apply to my work. The principles are as follows:

Piliriqatigiinniq - Working together for a common purpose.

Qanuqtuurniq - Solving problems by being innovative and resourceful.

Pijitsirniq - Serving others.

Inuuqatigiitsiarniq - Respecting and caring for others.

Tunnganarniq - Being open, welcoming and inclusive.

Aajiiqatigiinniq - Decision-making through consensus.

Pilimmaksarniq - Learning and mastering new skills.

Avatittinnik - Respecting and caring for the land, animals and environment. (RCYNU, 2021)

The principle *aajiiqatigiigniq* (consensus) and its value as an Inuit methodological approach to health research, including studies on mental health, has been explored by Ferrazzi et al. (2019). They point out that mental health and wellness studies, from the methodologies to ethics and reporting on qualitative research, have often not involved Indigenous perspectives or communities at all. One very important lesson learned from these authors was how to refer to knowledge or *IQ*. While the term "traditional knowledge" is often seen in literature, the authors noted that "many Inuit Elders are not comfortable with this terminology as potentially ignoring the very dynamic and adaptive nature of *IQ*" (Ferrazzi et al., 2019, p. 3). I thus refer to Inuit knowledge as "cultural knowledge" as suggested by the authors.

Certainly, the layers of my position as a settler at a Western academy will always limit the extent to which I can embody and contribute to decolonizing research within this field. Sium et al. (2012) capture this reality as follows:

> There is no escaping complicity within a settler colonial state, especially for those of us who have settled here, though complicity looks different for each of us. Complicity cannot be collapsed into simple and neat categories without historicizing the political legacy of colonialism and the way in which it manifested and continues to manifest itself both here and across the globe. (p. 3)

To reconcile my position and my conceptual framework, in this project, my methodological choices are less about which tool I choose and rather the *ways* in which I apply it. For instance, I chose two very standard and flexible data collection approaches: document review and semi-structured interviews. To apply them, I ensured that the data collected during my document review and qualitative interviews came not only from non-Indigenous sources, but also from Inuit-operated or representing sources. I selected semi-structured interviews—which I referred to as "discussions" as much as possible when speaking to participants—to defuse notions and feelings of hierarchy as much as possible. I hope that my attempts to be flexible in my ways of thinking and doing will be apparent throughout this study.

In the next section, I outline my approach to data collection through documents and interviews.

4.2 Data and data collection

In this section, I outline my two-part data collection process. First, I describe my policy document collection process and present a corpus of the data retained. I then present my interview process, including ethical protocol, recruitment methods, the participants, and the interview guide.

4.2.1 Document collection process

For the first part of my research, I collected policy documents from government-funded mental health service providers serving Nunavut. The documents were retrieved electronically using Google. To select documents, I first determined if the service providers found met two criteria: they provided mental health services to Nunavut (regardless of their operating location) and they receive funding from or have services procured by a municipal, provincial/territorial or federal government. My method was as follows:

1. I established a list of eight providers that I found through conversations with people in my professional network: Morneau-Shepell, Homewood Health, Hope for Wellness, Kids Help Phone, Health Canada Northern Program, Thrive Health, LivingWorks, and Kamatsiaqtut Helpline. I used these providers as a starting point for my document search.
2. I conducted a number of searches by entering keywords or phrases into Google. I used a combination of keywords related to mental health services in Nunavut to perform my searches and looked at sources that appeared on the first three pages. My key phrases were:
    i. mental health services in Nunavut
    ii. mental health services in Inuit language
    iii. counselling in Inuktitut
    iv. mental health services in Inuktitut
    v. Inuit wellness programs in Nunavut
3. I followed any links on the first three search pages that I thought might provide me with answers, and I recorded any relevant documents that came up.
4. I looked through reports pertaining to mental health produced by municipal, territorial and federal governments, as well as community organizations (such as those consulted for my

literature review) for mentions of mental health service providers in Nunavut, to account for providers that may not have been found using my first step.

5. I recorded basic information in a matrix that broke down each provider's service offer by region (i.e., whether the provider was in Nunavut and/or served other provinces), funding government, and mode of service delivery. This matrix is presented and discussed in the Results chapter of this thesis. I then browsed the provider's website further for any documents or pages mentioning language of service.

By my fourth search, no new services or supports appeared, which indicated to me that I had reached saturation.

4.2.1.1 Corpus

To consolidate the results of my searches, I compiled my findings into a list of programs and documents found (Table 1). In the case of this study, websites, and webpages themselves qualify as documents, as do documents found there within.

Table 1 - Programs providing mental health support to Inuit people in Nunavut and policy documents produced by providers

	Name of program	**Documents retrieved**
1	Indian Residential Schools (IRS) Health Support Program	Webpage detailing information about the program, eligibility, and services available. Indian Residential Schools Resolution Health Support Program (sac-isc.gc.ca)
2	Hope For Wellness Help Line	Webpage: Hope for Wellness Chat
3	Kamatsiaqtut HelpLine	Website home page, About page and Helpline page: Home - Kamatsiaqtut Nunavut Helpline
4	Kids Help Phone	Website Finding Hope Youth Action Plan: Finding Hope: Indigenous Youth Action Plan - Kids Help Phone
5	Veteran Affairs Canada Assistance Services	Webpage: Talk to a professional - Veterans Affairs Canada

6	GN Employee and Family Assistance Program	Webpage: Employee and Family Assistance Program | Government of Nunavut
7	Pulaarvik Kablu Friendship Centre	Inuusivut Anninaqtuq Action Plan 2017-2022: inuusivut_anninaqtuq.pdf (gov.nu.ca)
8	Unipkaaqtuaq (telling stories)	News article https://nunatsiaq.com/stories/article/nunavut-promotes-wellness-through-reading-during-pandemic/
9	Reclaiming the Whole Man/Woman	Webpages Reclaiming the Whole Man - Pirurvik Centre Reclaiming the Whole Woman - Pirurvik Centre
10	Ingalangaittukuurvik	Webpage Ingalangaittukuurvik - Pirurvik Centre
11	Arviat Young Hunters Program Ujjiqsuniq Project	Inuusivut Anninaqtuq Action Plan 2017-2022 inuusivut_anninaqtuq.pdf (gov.nu.ca) News release Young Hunters Program offers Inspiration - Canada.ca
12	Kivalliq Art Camp	Webpage Cultural Programs - Kivalliqinuit
13	Pijunnaqsiniq Cultural Camp	Webpage Cultural Programs - Kivalliqinuit
14	Somebody's Daughter Camp	Webpage Cultural Programs - Kivalliqinuit
15	Zippy's Friends	Inuusivut Anninaqtuq Action Plan 2017-2022 inuusivut_anninaqtuq.pdf (gov.nu.ca)
16	Northern Counselling and Therapeutic Services	Website Northern Counselling & Therapeutic Services (NCTS) Visited: Home page; About page; Counselling Services page; Employee Assistance Program page
17	Inuusittiaringniq (Living Well Together)	Website Home | Healthy Living (gov.nu.ca)
18	Crisis Services Canada	Website Canada Suicide Prevention Service | Crisis Services Canada
19	Youth Space	Website Youthspace.ca
20	Inuit Child First Initiative	Web page Supporting Inuit children (sac-isc.gc.ca) Web page Child First Initiative - Inuit Tapiriit Kanatami Web page Inuit Child First Initiative | Inuvialuit Regional Corporation (IRC)
21	Embrace Life Council	Website Embrace Life Council | Home - Embrace Life Council (inuusiq.com) Funding letter provided by a Council representative
22	Inuutisarniq Literacy Program	Inuusivut Anninaqtuq Action Plan 2017-2022 inuusivut_anninaqtuq.pdf (gov.nu.ca)

4.2.1.2 Limitations of document collection

The start of my research project coincided with the onset of the COVID-19 global pandemic. Due to social distancing restrictions implemented by provincial and territorial governments, providers

of most services were forced to conduct all their business by virtual means, such as by telephone or online communication platforms. In addition, experts across Canada cautioned about the impacts that the pandemic would have on mental health and wellness, particularly in Indigenous communities. The urgency of helping people gave way to increased government funding for the rapid rollout of social programs of all kinds to support Canadians. However, transitioning to virtual operations meant that many programs and businesses may have been required to stop their operations, while others appeared on the market. Due to the rapid rate at which both permanent and temporary mental health and wellness services and programs are appearing and evolving across the country, my document search results are limited to a specific moment in time, which may be briefer than it would have been prior to the pandemic. It is hence important to note that my data were collected in the spring and summer of 2021.

4.2.2 Interviews

I conducted six semi-structured interviews with representatives of mental health service providers serving Nunavut to identify de facto and implicit language policies that were not otherwise found in my document review. The interviews also aimed to validate information found in documents, and served to answer the following research questions: 1) What challenges do mental health institutions face in the provision of services to Inuit in the Inuit Language?; and 2) What solutions could be envisioned to address these challenges?

In this section, I will first describe my ethics protocol, followed by my recruitment and interview protocol. I will then introduce the six interview participants and describe the interview guide provided.

4.2.2.1 Ethics

As is protocol, I submitted my project request to the University of Ottawa Board of Ethics. I subsequently received an email to inform me that my application had been closed as they had determined that I did not need to obtain an ethics approval to conduct my study as per the following described application of Article 2.1 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2:

> In some cases, research may involve interaction with individuals who are not themselves the focus of the research, in order to obtain information. For example, one may collect information from authorized personnel to release information or data in the ordinary course of their employment about organizations, policies, procedures, professional practices or statistical reports. Such individuals are not considered participants for the purposes of this policy. This is distinct from situations where individuals are considered participants because they are themselves the focus of the research. For example, individuals who are asked for their personal opinions about organizations, or who are observed in their work setting for the purposes of research, are considered participants. (CIHR, NSERC & SSHRC, 2018, p. 15)

This decision notwithstanding, I recognize that the Tri-Council's policy is jointly administered by three federal research agencies and is thus based on Westernized definitions of research and ethics. Following concerns about the exclusion of considerations for ethical research with Indigenous communities, the policy was updated in 2007, 2010 and 2014 to include a chapter on research involving First Nations, Inuit and Métis in Canada (Riddell et al., 2017). ITK and the Nunavut Research Institute (NRI) (2007) published a guide for researchers called *Negotiating Research Relationships with Inuit Communities* to assist researchers with engaging with Northern

communities. Although my research is not community-based, there are still some considerations I was able to take from this guide, such as framing my research questions in a way that maximizes "the relevance of the study to local needs and interest" (p. 11).

Reports produced by representative organizations like ITK indeed influenced my project theme and research questions. With regard to data collection, I asked colleagues and friends of mine with roots in the North to suggest names of people that would properly represent the needs and reality of mental health service providers. Further, to ensure the comfort and security of those who agreed to participate, I offered participants the option of confidentiality or anonymity if they so wished. I also asked their consent to record and transcribe our conversation for later analysis. Each participant was also sent any sections of this study involving their program in draft form to ensure that they were comfortable with the information being conveyed. Although this is not complete data sovereignty, it respects participants right to safety concerning how the data is used.

4.2.2.2 Recruitment

To recruit interview participants, I reached out to current and former professional contacts to ask them if any of the providers I was interested in were a part of their network and might be a good fit for my study. I prepared a short description of my study upon the request of each person, which they sent out in an email to their network, asking anyone willing to participate to contact me directly. I also contacted providers for whom I had no contact in my network using their organization's generic "Contact Us" online form. If no form was available, I called the phone number listed. Once I received a response from a potential participant, I asked them to indicate a date and time that was convenient for them within a determined time frame. If the participant replied with their availability, I sent them a Microsoft Teams invitation with a list of guiding questions attached. As mentioned at the end of section 4.1, I systematically referred the interviews

as a “discussion” or “conversation” when communicating with participants to remove any power dynamics as much as possible and help participants feel more comfortable.

4.2.2.3 Interview protocol

At the start of each interview, I proposed that we take turns introducing ourselves. I gave participants a brief description of who I am, what my study is about and why I am doing it. Once participants introduced themselves, I asked their permission to record our discussion and outlined what I would do with the data as well as privacy measures taken. Interviews lasted an average of 45 minutes and were done virtually using Microsoft Teams or by telephone, based on participant preference. I audio-recorded each interview and used the automated transcription function in Teams where possible. During and after each interview, I prepared reflective notes for future analysis. At the end of each interview, I informed participants that I would be following up with them to ensure that they were comfortable with any information involving them in this thesis.

4.2.2.4 Participants

I conducted interviews with representatives from the following six service providers:

1. Kamatsiaqtut Helpline
2. Embrace Life Council
3. Umingmak Centre
4. Kitikmeot Friendship Society
5. First Nations and Inuit Health Branch - Northern Region, Indigenous Services Canada
6. Iqaluit Mental Health, Government of Nunavut

While it is usually protocol to provide certain information about interview participants, such as their position title and field of work, I have elected not to describe them because of the small

populations in Nunavut's communities which allow for easy identification of members. I refer to each person as "participant" throughout.

4.2.2.5 Interview guide

I prepared an interview guide with seven guiding questions that were asked in a semi-structured style—i.e., not necessarily in order or word for word—to allow for flexibility and give participants the space to expand on their thoughts and the ideas they wanted to convey. Based directly on my research questions, the interview questions are as follows:

1. Could you please describe the mental health services that your organization/program provides in Nunavut?

2. Would you happen to know what percentage of your clientele is Inuit?

3. Are any of your services available in the Inuit Language?

    If yes: Which services?

        How are these services/programs provided (i.e., by way of interpreter, Inuktut-speaking practitioners)?

4. Does your organization/program collect data on the language preferences or abilities of your clients?

    If yes: What type of data do you record?

        How often are services requested in the Inuit Language?

        Are there any indications of the socio-demographic profile of the requesters?

5. How do you market and communicate your mental health services/program in Nunavut?

Follow-up: Do you market any of them in the Inuit Language?

6. What types of challenges do you face in providing services/marketing communications in the Inuit Language?

7. How do you think these challenges could be addressed?

4.2.2.6 Limitations of this data collection

The number of qualitative interviews conducted for this study was limited by several factors and exacerbated by the COVID-19 pandemic. First, many service providers in Nunavut are in remote locations with limited connections to virtual communication. Second, although willing, a number of providers were unable to meet with me due to time constraints brought on by increased demand for mental health services in the context of the pandemic. Third, and particularly in the case of the governments of Canada and Nunavut, it was extremely difficult to reach the appropriate people who would have answers to my questions. My requests were often passed from one department to another. Finally, there were a few organizations that agreed to interviews, and simply did not present themselves at the time arranged or did not reply when asked about availability.

In the next section, I explain the protocol by which I analyzed the data.

4.3 Data analysis

In this section, I first describe the mixed method approach I took to data analysis. I then outline the specific steps I took using reflexive thematic analysis to analyze my documents and my interviews. Lastly, I describe how I applied critical discourse analysis (CDA) to both my documents and interviews.

4.3.1 Mixed-method analysis

I use a mixed method for my analysis, combining thematic analysis and CDA to look at patterns in the data I collected and at what underlying meanings these patterns may suggest. I elected to use reflexive thematic analysis as conceptualized by Braun and Clarke (2006) for the analysis of both documents and interviews because of its flexibility. The authors define this type of analysis as "a method for identifying, analyzing, and reporting patterns (themes) within data" (p. 6). This method is particularly appropriate for this study as it supports different researchers' positionalities and a wide range of conceptual frameworks, such as the decolonial framework, thus allowing analysis to move beyond colonial systems of thought. Braun and Clarke propose six steps to their analysis but leave them open to adaptation and interpretation: 1) getting familiar with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; 6) writing the report. In the case of my document analysis, I combined steps 1 and 2, as well as steps 3, 4 and 5 of Braun and Clarke's method. To analyze my interviews, I worked through the authors' entire six-step process.

Throughout my data collection and analysis important observations were made surrounding discourse. I therefore decided to examine use of language on the part of Westernized providers and Inuit providers in both documents and interviews. To do this, I used critical discourse analysis (CDA). Fairclough et al. (2011) define CDA as a "problem-oriented interdisciplinary research movement" united by "a shared interest in the semiotic dimensions of power, injustice, abuse, and political-economic or cultural change in society" (p. 357). CDA suggests that there is a semiotic element to all social practices and that this meaning making can point to relationships between language and power. This method is not rooted in a particular theoretical or methodological stance and can be applied to a research topic of choice; in this case, decolonizing language policy.

Although CDA has proven useful to highlight how discursive practices create and perpetuate social, political and economic power imbalances (Fairclough et al., 2011), it has been criticized for being biased by the researcher's stance (Fairclough, 2001). Billig (2008) suggests that since CDA examines the use of language, critical discourse analysts should also consider how they themselves use language. He notes that:

> If critical analysts use the same forms of language whose ideological biases they are exposing in others, then they might be uncritically and unselfconsciously instantiating those very biases (p. 784).

I therefore take this call for self-reflexivity into account in my analysis by examining my own use of certain terminology while highlighting distinctions and best practices put forward by participants.

Researchers have explored several approaches to CDA in a variety of disciplines, including a transdisciplinary approach (Fairclough, 2012), sociocognitive approaches (e.g., van Dijk, 1996), a discourse-historical approach (Reisigl and Wodak, 2001), and corpus-based approaches (e.g., Mulderrig, 2011). When examining potential approaches to CDA that I might use to best analyze my data, I noted two things: 1) The authors who developed CDA are largely European (i.e., Fairclough, Wodak, Mulderrig, etc.); and 2) The context in which they propose analytical frameworks is thus also European. I thus sought to establish which analytical framework was the least prescriptive and contextualized to ensure that it could be approached from a decolonization standpoint. Fairclough's (1995) three-dimensional CDA framework seemed to most meet this requirement:

1. Analyzing text, both written and spoken

2. Analyzing discourse practice, i.e., the production, distribution, and consumption of text

3. Analyzing discursive events as social practice

This framework allows for the analysis of what is being communicated, how it is communicated and by whom, while applying and highlighting decolonizing practices. Consistent with all my methodological choices, I am refusing the potentially prescriptive nature of the CDA framework to challenge Eurocentric perspectives on methodology, which are highly linear in nature.

On the subject of refusal, particularly with respect to communicating my research results, I gave consideration to the following:

> the refusal stance pushes us to *limit* settler territorialization of Indigenous/Native/community knowledge, and *expand* the space for other forms of knowledge, thought-worlds to live. (Tuck & Yang, 2014, p. 817)

To apply this notion, I present my interview analysis and part of the CDA section largely through quoting participant interventions. The participants represent mental health and wellness service providers and are thus best positioned to convey the realities of language policy in mental health provision in Nunavut. Further, a number of participants provided an unanticipated depth of responses which allowed me to communicate the results and analysis in somewhat of a narrative.

In the next three sections, I outline the steps I took to analyze documents and interviews, first through reflexive thematic analysis, and second, using CDA. It is important to note that, although these steps are numbered, each analytical process was iterative.

4.3.2 Documents

To analyze my documents, I took the following steps based on combining steps 1 and 2, and steps 3, 4 and 5 of Braun and Clarke's reflexive thematic analysis framework:

1. I looked for patterns in the various service offers and generated codes. I created a matrix to present my results, using the codes as headings.
2. I visited some of the websites based on the codes to examine language practices further and populate the matrix.
3. I reviewed both the matrix and notes I had taken when visiting the websites to establish and name themes.
4. I wrote my analysis.

4.3.3 Interviews

I analyzed my interviews through the following process, adopting all six steps of Braun and Clarke's framework:

1. I listened to the audio recording of each interview one after the other and noted potential codes. I primarily used in vivo coding during this process.
2. I looked at all the potential codes and compared/validated them with the notes I took during the interview and my reflexive entries written after each interview.
3. I used the codes to develop themes for my analysis.
4. I reviewed and named my themes.
5. I cross-referenced the themes established during my document analysis with the themes stemming from my interviews.
6. I wrote my analysis.

4.3.4 Analysis of documents and interviews using CDA framework

Using Fairclough's three-dimensional CDA framework, I analyzed text (written and oral) from both my documents and interviews as follows:

1. I used NVIVO12 to generate word clouds that compared language used on the webpages of national mental health service providers versus community-level providers.
2. I noted down initial patterns noticed in the word clouds.
3. I looked at my interview notes and transcripts to identify patterns that were similar to or different from those I noted in the word clouds.
4. I looked at how the text was presented on webpages and cross-referenced it with the discourse practices described by interviewees.
5. I used interview data to analyze discursive events as social practice.

In the next chapter, I present and discuss my analyses.

CHAPTER 5: RESULTS AND DISCUSSION

In this chapter, I first present the results of my thematic analysis of documents, followed by results stemming from my thematic analysis of interviews. Finally, I present a critical discourse analysis of both data sources combined. I have chosen to provide discussion along results so as to contextualize the information and highlight decolonizing perspectives as they appeared progressively through the analysis.

5.1 Thematic analysis of documents

In this section, I first summarize the information about mental health services and supports found during my document search. I then provide a thematic analysis of the documents collected.

5.1.1 Summary of mental health services and supports

Table 2 provides a summary of the information pertaining to the 22 mental health services and supports that appeared during my searches. This information is broken down by program, provider, type of service, method of delivery, area service and language offerings.

Table 2 - Profiles of Mental Health Programs in Nunavut

	Name of program	Provider	Type of service or support	Method of delivery	Area served	Indications of language of service
1	Indian Residential Schools (IRS) Health Support Program	Indigenous Services Canada	Counselling services for survivors of IRS and their families	Telephone	All of Canada	No language indicated
2	Hope For Wellness Help Line	Donna Cona	Counselling and crisis intervention for Indigenous peoples	Telephone or online chat	All of Canada	Explicitly listed: English, French, Cree, Ojibway, Inuktitut
3	Crisis Services Canada	Crisis Services Canada	Crisis intervention and suicide prevention services	Telephone, online, text messaging	All of Canada	No language indicated

4	Youth Space	Youth Space	Emotional support and crisis chat line	Instant messaging, text messaging, telephone	All of Canada	No language indicated
5	Kids Help Phone	Kids Help Phone	Counselling and crisis intervention for children and youth	Support forums, text messaging, telephone, Facebook Messenger, live chat	All of Canada	No language indicated
6	Veteran Affairs Canada Assistance Services	Veterans Affairs Canada	Mental health services for Canadian Armed Forces Veterans, former members of the RCMP, their families and caregivers	Telephone, peer support, self-help website and application	All of Canada	Indication of "bilingual" counsellors
7	Kamatsiaqtut HelpLine	Kamatsiaqtut	Counselling and crisis intervention services for people living in the North	Telephone	Northern Canada	Explicit indication of English French Inuktitut
8	Northern Counselling and Therapeutic Services	Northern Counselling and Therapeutic Services	Counselling, emergency response, employee assistance program	In person, telephone	Northern Canada	No language indicated
9	Inuit Child First Initiative	Government of Canada	Program to provide Inuit children with health resources including services related to mental health	Telephone / in person	Inuit Nunangat	Implicit indication of Inuit Language as program posters are available in Inuktitut and Inuinnaqtun
10	Unipkaaqtuaq (telling stories)	Government of Nunavut and Inhabit Media/ Inhabit Education	Healing and wellness through story readings	Radio	Nunavut	Explicit indications of Inuktut
11	Reclaiming the Whole Man/Woman	Pirurvik	Series of classroom and outdoor courses to help participants connect with traditional skills, knowledge and language	In person	Nunavut	Explicit indication of Inuktut
12	Ingalangaittu kuurvik	Pirurvik	Program teaching wisdom to promote well-being	In person	Nunavut	Explicit indication of Inuktut fluency as a prerequisite for program

13	Zippy's Friends	Department of Education, Government of Nunavut	School-based emotional coping skills program for K-3 students	In person	Nunavut	No language indicated
14	Inuusittiaringniq (Living Well Together)	Government of Nunavut	Self-help website with informational resources related to health and wellness	Online	Nunavut	Implicit indication of Inuktut based on site languages offered
15	Embrace Life Council	Embrace Life Council	Information hub on suicide prevention for Nunavummiut	Online resource	Nunavut	Implicit indication of Inuktitut based on site languages offered
16	Inuutisarniq Literacy Program	Government of Nunavut	Program for K-3 students that combines health promotion, language and culture	In person	Nunavut	Inuit Language is explicitly indicated as reading language
17	Arviat Young Hunters Program Ujjiqsuniq Project	Aqqiumavvik Society	Training program that combines wellness and sustainable harvesting	In person	Arviat region	Implicit indication of the Inuktitut through images
18	Pulaarvik Kablu Friendship Centre	Kivalliq Outreach Program	Counselling and mental health activities such as art therapy	In person	Kivalliq region of Nunavut	Implicit indication of Inuktitut based on site language
19	Kivalliq Art Camp	Kivalliq Inuit Association	Camp to help Inuit heal from loss and grief through art	In person	Kivalliq region	Implicit indication of Inuktitut based on site language
20	Pijunnaqsiniq Cultural Camp	Kivalliq Inuit Association	Camp for Inuit youth to connect with their heritage and heal	In person	Kivalliq region	Inuktitut explicitly indicated as the language of instruction
21	Somebody's Daughter Camp	Kivalliq Inuit Association	Program for Inuit women to learn and share cultural knowledge	In person	Kivalliq region	Inuktut explicitly indicated as the language of instruction
22	GN Employee and Family Assistance Program	Homewood Health	Short-term counselling services	Telephone, videoconference, in person	GN employees	Explicit indication of English and French as well as Inuktitut and Inuinnaqtun through an interpreter

Of the 22 programs listed above, 6 operate on a national scale and 16 at a regional level. They cover a wide range of mental health and wellness services: counselling, crisis intervention, publications and other informational resources, classes and school-based programs, camps, etc. Most programs are delivered in person or by telephone, however other methods, including videoconferencing and various forms of chatting or instant messaging are also used, particularly in services offered to children and youth. Fifteen out of 22 websites provided information related to the Inuit Language, either in an explicit or implicit way, while the other 7 did not. Of the seven that did not, five operate on a national scale, and two on a regional scale. It should be noted, however, that although not indicated on their website, these providers may in reality offer services in the Inuit Language. Only one national service indicated availability of any Indigenous language, as the country's national helpline for Indigenous peoples.

In the matrix, I also distinguish between implicit and explicit language of service offers. I assume that if a service is described in a specific language, that indicates availability in said language unless otherwise indicated by a special note. In the case of national services where "no language indicated" appears, this refers specifically to the Inuit Language, as the websites of these services were all available in both English and French.

In the next section, I present the results of my thematic analysis of documents produced by those 22 providers. In Section 5.3, I present further observations regarding documents which were generated through the CDA method.

5.1.2 Themes stemming from document analysis

As presented in Chapter 4, my corpus consists of websites and documents pertaining to the services of 22 mental health service providers. My analysis is organized along the three LPP processes (status, corpus, and acquisition) presented in Section 3.2. The first section pertains to status of the

Inuit language in national and regional mental health programs (status planning). The second section addresses decolonizing mental health through acquisition planning. The third section focuses on the expansion of the Inuit Language for improved mental health programs (corpus planning).

5.1.2.1 Status of the Inuit Language in national versus regional mental health services

As evidenced in Table 2, most regional mental health programs advertise service availability in Inuktut, while most national ones did not indicate language offers beyond English and French. This may mean that many of the 76.6% of Inuit who declared Inuktut as their dominant language in the 2016 Census do not have access to national mental health programs and services in their dominant language. As mentioned previously, it is possible that some of these programs provide interpretation services, but did not indicate it as such on their websites.

Nunavut's *Inuit Language Protection Act* (ILPA) (2008) requires that organizations providing essential services, including health services, make them available in the Inuit Language. Based on the fact that this legislation defines "organization" as "a public sector body, municipality or private sector body" (ILPA, Interpretation, p. 3), the Indian Residential Schools Health Support Program, Kids Help Phone, Crisis Services Canada, Youth Space, and the Veterans Affairs Canada Assistance Service should deliver services in Inuktut when operating in Nunavut. However, there has been a longstanding debate as to whether the federal government is subject to the ILPA. After seeking legal advice, the federal government claimed that it is not subject to territorial law as that extends beyond the authority of the ILPA and Section 35 of the Constitution of 1982 (Robinson & Power, 2013). The Office of the Languages Commissioner of Nunavut for its part mentions this debate each year in its Annual Report. The most recent report (2018-2019) states:

> The federal government had been adamant that they are not obligated to provide Inuit language services in Nunavut. The *Indigenous Languages Act* of Canada does not in its entity say the federal government is obligated to comply with Nunavut's language legislations, however Section 44 of the Act is written declaring that a treaty or a land claims agreement prevails over the inconsistency or conflict therefore obligating the federal government to comply with Nunavut's *Inuit Language Protection Act.* The Nunavut's language legislations are prodigies of the *Nunavut Act* as the Government of Nunavut is a creation out of the Nunavut Land Claims Agreement. The Office of the Languages Commissioner will continue to pursue this issue with the federal agencies until it is satisfactorily resolved. (p. 55)

Thus, the status of the Inuit Language is clear up until the point that it intersects with federal institutions. Inuit therefore only seem to have access to national mental health programs if they accept to receive services in the same languages which were forced upon them. This sends a clear message about the status of the Inuit Language at the federal level and exemplifies how language hierarchies, and by extension language barriers to accessing services, can be sustained and perpetuated through language policy. Until resolved, this debate will continue to affect every sphere of Nunavut society where the Government of Canada is present, not least the provision of mental health services and supports.

In the next section, I highlight how Government of Nunavut and Nunavut-based organizations have used acquisition planning to decolonize mental health by way of language.

5.1.2.2 Decolonizing mental health through acquisition planning

When doing my document research, I expected to find Nunavut-based programs that were Inuit run and that implemented wellness concepts in line with Inuit ways of knowing and doing. From

a language perspective, one of those programs stood out. In 2020, the Government of Nunavut launched a program called *Unipkaaqtuaq* (telling stories), a wellness program for youth delivered through reading and storytelling. The program was designed as a way of supporting Nunavummiut through the pandemic. Local mental health workers provide books to families which are read, often by elders, over the radio so anyone can follow along. The books are provided by Inhabit Media and Inhabit Education, Nunavut-based companies that make culturally relevant educational resources available to parents and teachers. Inhabit Education (2021) describes its Social Emotional Learning series as:

> thoughtful, engaging stories that help school-aged children identify and learn to regulate their emotions in healthy ways. This series lays the groundwork for good mental health in stories children will want to revisit again and again. All titles are available in English and Inuktitut, with select titles available in French.

Several book titles begin with *Sometimes I feel* and then an adjective to describe an emotion, such as sad, angry, and left out. In addition to live radio-broadcast readings, *Unipkaaqtuaq* also provides recordings of stories being told by Inuit artists and authors. The program's design is an example of indigenized acquisition planning that provides two key solutions: facilitating access to mental health support for people in remote communities, which often to not have Internet access; and teaching readers and listeners words and expressions related to wellness in Inuktut.

Unipkaaqtuaq is not the only wellness program that incorporates Inuit Language acquisition into its objectives. The Pirurvik Centre specifically describes itself as being "dedicated to Inuit well-being through investing in our language and culture" (Piruvik, 2018). The centre's Reclaiming the Whole Man course specifies "Inuktitut terminology related to men's knowledge" as one of the topics addressed. Similarly, the Reclaiming the Whole Woman lists "Inuktitut terminology related

to women's knowledge" as a subject. These programs are thus not only focused on helping people heal, but also teaching them how to express themselves in Inuktitut in a wellness context.

The programs above do not reflect typical mental health services and supports that are used in Westernized spheres, such as counselling or wellness applications. Rather, they are designed by Inuit for Inuit and take holistic approaches to wellness in which language and cultural knowledge play central roles.

In the next section, I explain how objectives for expanding the Inuit Language itself also appear in the area of mental health.

5.1.2.3 Expanding the Inuit Language for better provision of mental health services

One document which appeared on a few provider sites, and in which several providers are documented, is *Inuusivut Anninaqtuq*, Nunavut's Suicide Prevention Strategy 2017-2022. It is a joint action plan between the Government of Nunavut, the Royal Canadian Mounted Police (RCMP), Nunavut Tunngavik Incorporated (NTI) and Embrace Life Council. It includes several objectives with regard to corpus planning, specifically to facilitate counselling services requiring Inuktut-English interpretation. The Department of Health, Quality of Life (QoL) Secretariat, Inuit Uqausinginnik Taiguusiliuqtiit (IUT), and Nunavut Arctic College (NAC) are tasked with the following:

- Developing a terminology guidebook for terms related to mental health (including terms related to grief and suicidal behaviour);
- Developing and delivering advanced terminology and skills development workshop for clerk medical interpreters on interpretation in counselling contexts;

- Including counselling-specific interpretation skills and terminology in NAC's interpreter-translator program (*Innusivut Anninaqtuq*, 2017, p.15).

Indeed, as shown in my literature review, research (Arafat, 2015; Bowen, 2001) indicates that language barriers to communication between a patient and mental health care practitioner, which includes poor interpretation services, can lead to misdiagnosis, inappropriate interventions, or patient drop-out. For some, language is a protective factor (Sivak et al., 2019), meaning that being able to use one's language while processing grief or trauma could contribute to increased feelings of safety, and thus the healing process on its own.

Under the ILPA, Nunavut's language authority, IUT, is responsible for promoting and protecting Inuktut, in addition to developing terminology and standardizing its use. Unfortunately, there were no indications in my online searches as to the progress of these initiatives through Nunavut's Suicide Prevention Strategy or elsewhere, even though these initiatives to expand the Inuit Language could contribute to improved interpretation services, better patient-provider communication, and perhaps an increase in patients who request services in the Inuit language.

In the next section, I provide thematic analysis of interviews.

5.2 Interviews

In this section, I first summarize parts of the interviews that describe services provided by each of the six participating organizations. The providers' profiles help to contextualize the analysis that follows, since understanding each provider's care model is essential to understanding information offered by the participants. In the following subsections (5.2.2., 5.2.3., 5.2.4. and 5.2.5), I address main themes that emerged from the interviews: 1. Dominance of English language, 2. Predominance of de facto policies, over de jure ones, 3. Strategies adopted to decolonize hiring

process, and 4. Attempts at decolonizing funding. My thematic analysis highlights current practices adopted by organizations to overcome service barriers and resist colonial practices through language, as well as challenges and needs with regard to language provisions.

5.2.1 Mental health service providers

Kamatsiaqtut Helpline

Kamatsiaqtut Helpline is a non-profit organization providing anonymous and confidential telephone counselling and crisis intervention to Northerners. This grassroots initiative was started by a local group of Inuit and non-Inuit community members who saw a need to provide crisis support in the city of Iqaluit, located in the Qikiqtaaluk (Baffin) region of Nunavut. They started out with two local phone lines, providing support for three hours each night. However, the demand was so great that people from outside the region also wanted to call in, but they would have to pay. Within a year, a toll-free line was installed to provide support to the other parts of Inuit Nunangat. The helpline is primarily run by volunteers who are trained in culturally competent crisis intervention. In 2015, Kamatsiaqtut formed a partnership with the Distress Centre of Ottawa to take calls overnight so that service can be offered to Nunavummiut 24/7, every day of the year. The name Kamatsiaqtut means "thoughtful people who care."

Embrace Life Council (*Isaksimagit Innusirmi Katujjiqaatigiit*)

Based in Iqaluit, Embrace Life Council is a non-profit organization that focuses on suicide prevention and intervention, as well as mental health and wellness in Nunavut through programs and training. Many of their services focus on teaching others trauma-informed practices, crisis intervention, and how to support someone experiencing abuse. Crisis intervention training programs include *Uqaqatigiilluk!* (Talk About It!), an adaptation of the Applied Suicide Intervention Skills Training (ASIST) developed by LivingWorks. Similar to ASIST, the Reach

OUT program teaches youth to recognize signs of suicidal thoughts and support people in getting the help that they need.

Embrace Life Council also has a number of courses designed by Nunavummiut for Nunavummiut. The Youth Self Injury workshop helps participants understand self-injury and how to support self-injuring youth. Our Children, Our Responsibility (OCOR) is a workshop that provides space for open dialogue surrounding child sexual abuse, preventing it, and steps to take when it is disclosed.

In addition to workshops and programs, Embrace Life Council also provides informational materials to communities on a variety of subjects, including addictions, bullying prevention, healthy relationships and suicide prevention. Materials include posters, pamphlets, videos and community resource cards, which are tailored to each community.

As previously mentioned, Embrace Life Council partners with the Government of Nunavut, the RCMP, and NTI to administer the *Innusivut Anninaqtuq* Action Plan 2017-2022, Nunavut's third suicide prevention action plan.

Umingmak Centre

Umingmak is the first Child Advocacy Centre in Nunavut and provides centralized services and support to children and youth who have disclosed numerous forms of maltreatment or abuse. To avoid retraumatizing children that they receive, and to provide them with a single stable environment, the Centre has an on-site clinic with consistent pediatricians for medical examinations and follow-ups, three assigned RCMP officers who are trained in doing forensic interviews with children, trauma therapy clinicians, advocates to help the child or youth and their family navigate appointments and services, and trained Inuit counsellors. The organization works with the RCMP, Qikiqtani General Hospital, Child and Family Services, and the Department of

Justice at the Government of Nunavut to coordinate the care process from start to finish. Umingmak Centre currently provides services primarily to Iqaluit residents, but occasionally supports children and youth from other communities in the rest of the Qikitani (Baffin) region who may be sent down for medication examination and interview with the specialized team.

Kitikmeot Friendship Society

Kitikmeot Friendship Society (KFS) is a non-profit community organization based in Cambridge Bay designed to bridge the gap for people who do not have access to adequate mental health care or support services within their community. There are contexts in which, depending on the support needed and whether a community member is Inuit or non-Inuit, the government may not provide support. KFS liaises with other community organizations to provide an extensive range of programs geared toward mental and social health, culture, capacity building and general wellness. Mental health and wellness programs include Hunt & Heal, healing support groups, suicide prevention workshops, and parenting and health relationship programs. KFS identifies where there is a need for specific services or programming and attempts to fill that gap within communities. E.g., reading clubs, family activity nights, and programs that promote father-child bonding. KFS also provides services that are extensions of Umingmak Centre and Piruqatigiit Resource Centre for the Kitikmeot region.

Indigenous Services Canada, First Nations and Inuit Health Branch - Northern Region

The First Nations and Inuit Health Branch (FNIHB) in the Northern region is responsible for administering federal support for the mental health and wellness in First Nations and Inuit communities. In 2006, the Government of Canada received a court mandate to provide emotional, cultural and mental health support to former students of the residential schools and their families as a part of the Indian Residential School Settlement Agreement. FNIHB is responsible for the

operation of the Indian Residential Schools Resolution Health Support (IRS) Program in Yukon, Northwest Territories and Nunavut. Through IRS program, FNIHB provides clinical counselling services to program participants by establishing agreements with service providers, accommodating their travel, meals and lodging for them to be able to go into communities on a monthly basis to provide counselling support. Previously, clients were being flown out of their communities to receive care. This practice was changed over the last five years as travel costs were outweighing therapy costs and thus not meeting the actual needs of the communities. The service model in place today is not only more cost efficient, but also promotes sustainable well-being by not displacing people from their communities and support networks to receive care. Service providers are primarily hired from within Nunavut, if possible, within community, and are provided with a flat rate of compensation pay, including travel per diems where necessary. If there are language needs that the counsellor cannot meet, they will engage a local and trusted community member, such as an Elder, who can translate or interpret. FNIHB funds all translation and interpretation services under this program.

FNIHB also provides non-insured health benefit (NIHB) mental health counselling funding to the Government of Nunavut, which can be used for various programming under the NIHB policy framework. One of the programs developed with this funding is the Healing by Talking program administered by the Government of Nunavut's Mental Health and Addictions team. Healing by Talking provides virtual counselling services to clients via telephone or videoconference. A designated program coordinator, who helps organize appointments for clients, is able to do this intake in Inuktitut. Although the program does not currently have any Inuit counsellors, all have Northern experience and have been trained on the historical and cultural aspects to providing mental health services to Inuit. The Government of Nunavut also developed a clinical handbook

with Nunavut-specific scenarios to support clinicians in their work. There is currently a growing demand for the program in several communities.

Iqaluit Mental Health, Government of Nunavut

Iqaluit Mental Health is a directorate within the Department of Health at the Government of Nunavut. Prior to the COVID-19 pandemic, the group provided counselling services as well as support groups for addictions recovery and cognitive behavioural therapy (CBT). The onset of the pandemic prompted the group to explore other service models including virtual and telephone counselling and support groups. Currently, the team primarily delivers counselling services using a same-day counselling drop-in program. Community members are able to call in to arrange an appointment with counsellors who are on-site three days a week or available virtually. Where determined necessary, community members may also receive continuing support. The team does not currently have any Inuit counsellors but does have a clerk interpreter available in case of requests for Inuktitut.

In the next sections, I present the main themes that emerged from my analysis of interviews.

5.2.2 Dominance of the English language

The consensus among all providers was that English language is overwhelmingly dominant in regional centres such as Iqaluit and Cambridge Bay, and thus their programs are administered primarily in English.

Use of English may be partially explained by the 2016 Census data showing progressive decline in the number of Nunavummiut reporting Inuktut as their first language, speaking Inuktut at home, able to conduct a conversation in Inuktut, and having knowledge of Inuktut under the age of 34. Conversely, there has been a steady increase in the number of Inuit reporting knowledge of English

or bilingualism, with 94.1% of the population indicating an ability to conduct a conversation in English (Lepage, Langlois & Turcotte, 2019).

However, the 2016 Census data indicates as well that there are more Inuit than non-Inuit in Nunavut, and that close to 80% of the population declares Inuktut as their mother tongue. While the service provision in English could be consistent with the linguistic landscape in Cambridge Bay, where only 24.7% declare Inuktut as their mother tongue, the same logic does not apply to Iqaluit, where this number is 73.1% (Lepage, Langlois & Turcotte, 2019). Therefore, with the exception of the Kitikmeot region, the dominance of English cannot be rationalized by the population make-up.

What could explain this tendency is the legacy of the colonization and linguicide where the Inuit population, now administering mental health services, lacks confidence in their Inuit langue skills, as attested by one of the providers interviewed in this research:

> Because my mom is a product of residential school, her language was stripped from her at a very young age, and we grew up in a predominantly English-speaking community and an English-speaking household, I'm lucky to understand certain phrases and questions and words.

The dominant presence of English seems to be perceived as a *fait accompli* by service providers. One of the interviewed explained, "Well technically, Iqaluit's dominant language is English, and a lot of our program facilitators are English dominant." Another one noted that there is a tendency to use English even among Inuktitut speakers: "In Iqaluit, I would say, even our caregivers who are very fluent in Inuktitut, it's unfortunate, they will lead with English."

Some also conveyed the impression that services in English are generally more sought after than those in the Inuit Language: "For the most part, since we've opened, we haven't had a unilingual (Inuktitut) individual." It is, however, unclear whether Inuit support the use of English or they experience linguistic insecurity using Inuktut, even when they have limited English skills, as attested by one provider's testimony below:

> In Iqaluit specifically, even though the community is English mostly, there are participants who come from smaller towns and they speak Inuktitut, and they're more comfortable in Inuktitut. But when they participate in the programs, they are very shy and, I find, if they have broken English, they will be very to themselves and decide just not to speak, and that is a big barrier with letting yourself go, just being yourself, it takes a much longer time for them to be comfortable.

The excerpt provided above testifies to the difficulties potentially related to the service provision in English. In addition to affecting participants' general level of comfort in a program, and thus their ability to benefit from it, the providers interviewed also noted that language of delivery and who delivers it affects people's engagement in the activity:

> For other communities, the programs that could be provided a lot of the times are presented by non-Inuit or people (…) who are more comfortable in English, so a lot of participants would lose their focus or lose their interest in the whole program, because it's not provided in Inuktitut.

The emotional and cognitive complexity of processing traumatic events in one's non-native language can also significantly impact an individual's narrative, how it is understood by the mental health professional, and how they experience the healing process, all of which can reduce the

effectiveness of treatment (Bailey et al. 2019). One provider explained the importance of nuance in the context of a group wellness session:

> English translations from Inuktitut are sometimes just words that mean the closest to it. So, if you're facilitating or presenting in Inuktitut, there might be a really strong word that you will be able to share and will be very meaningful to someone, but trying to explain it to someone will lose its touch. It will have a smaller impact than it would in Inuktitut.

Some providers indicated that they could think of instances where clients may have felt more comfortable speaking in Inuktut than in English, and some have even asserted this right:

> There was a really important meeting about mental health and (…) there was a man there who is Inuktitut-dominant. He walked out right at the beginning of the meeting because they didn't provide a translator, and he just wasn't going to go through it. So he just said in Inuktitut "I'm not going to be here. There is no translator, you should always have a translator, I'm going to go."

The situations reported in the interviews, where clients felt shy using Inuktitut, did not fully benefit from the service provided, or did not demand services in Inuktitut in spite of poor English skills beg the question of how many Inuit are aware of their language rights?

Government departments at both the federal and territorial levels are required by territorial law to actively offer services to the public in Nunavut's official languages, which includes the Inuit Language. According to subsection 12(7)(a) of Nunavut's *Official Languages Act* (2008), an active offer constitutes "making it known to members of the public that they have the right to communicate and receive available services in their Official Language of choice" (OLA NU, 2008, p. 9). As mentioned in my document analysis, federal government compliance with Nunavut's

language legislation remains a point of contention. In the case of this research, no provider was able to specifically pinpoint at exactly which point an active offer was made or by whom. This could indicate that perhaps the active offer is not always available or that only those involved at initial intake processes are familiar with the official policy and responsible for respecting it. Alternatively, it could mean that those requesting services are unaware of their rights or that they accommodate the system in cases where accessing services in English may be better than no services at all.

If Inuktut is the mother tongue of the majority of Nunavummiut, but providers note a dominant presence of English, then this means Inuktut-speaking individuals either do not have adequate access to services at all, are not using the services available, or are willingly or unwillingly using English to accommodate the institutions that are meant to be serving them.

Aware of those realities, all providers expressed a desire to offer more services in the Inuit Language but also their reticence about the feasibility of this project, especially because of the financial resources and the access to education. Here are some of their responses:

> I definitely see a strong need (…) especially in our region. We need a lot of people who can speak Inuktut and/or translate (…) and having materials in the languages important. It can be quite costly but it is necessary to provide as much service in Inuktut as possible.
>
> If I really wanted to fix it and not just put a Band-Aid on it, I think everyone should become bilingual, but that's a really big goal.
>
> It would be really amazing if we had translators all the time to not only just translate the English part, but to understand the content of what we're presenting. And just always have two people there to facilitate in both languages. I think any program should have

> that. And if not two people, then one really amazing person who could do the work of two (…) and pay them like they're two people.
>
> If we had somebody who was Inuktitut-speaking, I think it would be valuable. I think it would be utilized.
>
> I would love to see Inuktitut-speaking counsellors. I think that's been the biggest barrier for Nunavut, having individuals who can speak the language fluently and have their degrees under their belts who can provide that service directly.

The quotes above explain that although mental health service providers may be very willing to offer services in Inuktut, they experience certain barriers. Their reflections allude to the themes I will be discussing in my next sections, namely, de facto linguistic policies, hiring of qualified personnel, and funding.

5.2.3 De facto language policies and practices

There were no official language policies reported among those I interviewed, and language provisions and practices varied based on their particular service offer and community context, and especially, who the facilitators and participants are. In a very few cases, providers have established Memorandums of Understanding or contribution agreements with the Government of Nunavut under which the government assumes responsibility of meeting language requirements. For the most part, however, they provide services in Inuit Language on an as-needed basis depending on the nature of the program and the community in which is it being held. They ensure these services in the following ways:

1. Hiring Inuit staff or volunteers who have some proficiency in Inuktut.
2. Working with a community member and asking them to translate.

3. Hiring professional translators or interpreters.
4. Involving Elders in their programming.

To balance staff availability and language needs, one provider developed a practice whereby Inuktut-speaking counsellors are available at a certain time of day. For anyone calling outside those hours who would like to speak to someone in Inuktut, they are told to call back at a certain time. With the help of a partnering organization, they also track the language preferences of their callers, and are thus able to establish when they receive the majority of callers requesting Inuktut:

> Especially between 6:00 and 8:00 every night, I try to have someone who speaks Inuktitut on, so at least for those two hours every day, people know that they can get somebody. And then, certainly from 8:00 to 11:00 we have someone on who speaks Inuktitut, but, you know, I can't guarantee that.

Providers without such planned language provision practices may use ad hoc interpreters, such as caregivers or Inuktut-speaking staff. However, staff members are not compensated for going beyond their job description. One provider noted:

> We did have one of our staff who was fully bilingual and also trained in forensic interviewing, and so she did in the past interpret some of the interviews, but I eventually pulled them from that because it essentially was not in their job title.

When doing programming in the communities, being connected with local people who are trusted and speak the language means that they can vouch for programs or services so that people feel more comfortable accessing what it being offered:

> With us going in to do the work, already we are perceived to be strangers, which we are. But if there is a local person who speaks the language, who understands the culture and traditions, then it's been very helpful, and people gravitate to that easily.

However, working with a local community member requires networks and trust:

> I'm really lucky because I have a base in Taloyoak, and one of my colleagues that will be coming on has a good base in Gjoa Haven, so we're able to really navigate and reach out to those communities and know who the best person is to work with us.

There are cases where providers recognize that working with official interpreters is critical to a program. For instance, when the Truth and Reconciliation Commission began its mandate, a decision was made to start the national consultation process in the North. In this case, it was essential to ensure the confidentiality, safety and security of the individuals sharing their story:

> We made sure that those interpreters were available specifically for the former student to express themselves. (…) This was to ensure that that student had full access to understanding what was happening through this process.

Even with professional interpreters, specific knowledge of the field and dialect are required since both Inuktitut and Inuinnaqtun have several dialects, some of which may co-exist within a single community:

> It's not just enough to have somebody who can interpret, it's a bigger package of having somebody who has the appropriate terminology for such questions and who also has more experience within that, and who also is able to receive additional support, because it's not a very easy interpretation job.

On the subject of terminology, one provider explained:

> Some of the terminology that Westerners use, they wouldn't have proper terminology in Inuinnaqtun or in Inuktitut. It would be very hard to express certain feelings or emotions that a person might be going through.

Therefore, finding an available interpreter who possesses this specific knowledge and who speaks the required dialect was highlighted as a challenge. In other cases, non-profit organizations do not necessarily have the funding required to hire official interpreters for all of their activities.

The most noted practice to ensure knowledge of culture and language in programming was working with Elders. The connection between cultural programs and the language in which they are provided was observed by most providers. I asked one provider if they thought there were any contexts in which the Inuit Language would be more suitable than English with regard to their programs and services. They indicated: "When it's a cultural program and its values are deeply connected, especially to the facilitator, that's the time when they should be in Inuktitut so they can give their confident input to the program." As keepers of oral tradition and teachers of cultural knowledge, Elders can be engaged in wellness programs which incorporate these aspects.

Although providers are aware of the connection between knowledge and language, seldom are programs delivered exclusively in Inuit Language. Various forms of bilingualism involving Elders were most often cited as common practice:

> If we have our Elders there, it will be predominantly bilingual. If we have youth who speak English, it will be English. It just depends on the situation and the community we're in.

In some cases, programs take on a bilingual format to accommodate participants and allow for effective expression of cultural practices. Inuit youth in particular have access to multiday land-

based programs where they are accompanied by Elders, coordinators and social workers as they spend time learning traditional hunting and survival skills, songs, stories, and more. It was noted that youth appear to practise receptive bilingualism, where they may not fluently speak Inuit Language, but they are able to understand it:

> Usually, we will have an Elder in the program that is going to sing cultural songs, the *ayaya* songs, in Inuinnaqtun, that is going to tell stories in Inuinnaqtun, that is going to share some of the traditional ways and traditional medicines and healing components in Inuinnaqtun, and the young kids will understand, but when it comes to responding back, they will use a common lingua that everyone understands, which is like one word response.

It was also noted that bilingual formats can present challenges when participants have varying levels of proficiency in the Inuit Language. Some might be more comfortable in it, others may understand it but not speak, and some neither speak nor understand it.

Similarly, numerous dialects can also affect the level to which participants are willing to engage in the activity. One participant shared the following:

> I always say that there’s different culture in each community. It depends on where you are and which group of people you’re dealing with. There’s so many dialects in the smaller communities that they tend to stick with their own group.

Despite the perceived strong link between culture and language, one provider noted that Inuit Language proficiency, especially in youth, should not be used to pass judgment on how connected one might be to their culture or Inuit identity:

> We do try to explain. If there were someone speaking in Inuktitut, we try to explain in English for that specific individual (a participant who does not speak Inuktitut). We support them, we let them know that it's okay. Even though we should have everything in Inuktitut, we also need to be there to support the ones who can't speak Inuktitut.

They illustrated their point anecdotally by describing a situation where a program participant who had no knowledge of Inuktitut was included on a hunting trip and ended up being the only one to successfully capture a seal. Indeed, communicating goes well beyond words:

> A lot of the teaching of cultural practices is not lectures, it's watching. That's a big part of Inuit cultural practices. We don't read too much or we don't write too much, but if you're always watching and participating, then you learn a lot more that way.

Therefore, *doing* can also be a form of language. Regardless of the language dynamics in their programs, providers indicated that they make every effort to make all program participants feel included and welcome. It can be observed that language is not addressed as a singular characteristic in community programming, but rather woven into a holistic approach to wellness, where it is a vehicle of culture and tradition. Thiong'o (1992) explains this connection as follows:

> Language as communication and as culture are then products of each other. Communication creates culture: culture is a means of communication. Language carries culture, and culture carries, particularly through orature and literature, the entire body of values by which we come to perceive ourselves and our place in the world. (p. 16)

Decolonial notions of language thus consider it as part of a greater whole, as a vehicle and reservoir, as opposed to a mere tool. Tagalik (2010) explains that "For Inuit, conceptual development will always be strongest in Inuktitut and, therefore, the strength and capacity of a

people is best developed from the strength of their linguistic and cultural context" (p. 6). Many of the practices and reflections shared by providers are consistent with this notion and with research findings (Kral, 2016; Newell et al., 2020) that associate language, when connected to Inuit-specific cultural practices, with positive health outcomes.

In the next section, I discuss practices and challenges that providers experience with regard to hiring and capacity.

5.2.4 Decolonizing hiring practices

Having qualified Inuktut-speaking staff was unanimously described as a challenge. Providers mentioned having very few bilingual staff and struggling to hold on to them. This was not so much attributed to the number of Inuit who speak Inuktut, but rather the number of Inuit who also met the professional requirements of the job or were willing to participate. Staffing is a known and ongoing challenge in the North with varying perspectives on why. One interviewed provider attested: "As you know, capacity is such a big issue that there's constant turnover, so you have a lot of your staff go through the training and then they're gone."

In addition to high turnover, Westernized qualification requirements were highlighted as a barrier to Inuit employment. Westernized mental health providers traditionally have specific qualification requirements when it comes to hiring counsellors or mental health support works, including a degree (e.g., Master of Social Work), a requirement to belong to a professional association or regulatory body, and being insured to provide the service. These are seen as accountability mechanisms to prevent malpractice and any harm to people. One participant cautioned that "There are also individuals who profess to be skilled and trained who are misrepresenting themselves," and asserted that "The greatest need is more individuals who are able to meet those qualifications and to be able to provide quality services."

Inuit who possess such credentials are few and far between. One participant shared that her knowledge is often devalued when encountering people who subscribe to Western definitions of qualifications: "Because my last name is an Inuit last name (…) I tend to have people down South question my capability of doing things here."

Knowing that availability and training are barriers to providing adequate services, grassroots organizations such as Kamatsiaqtut design their own training programs which they administer to all staff, whether Inuit or non-Inuit. Providers also spoke of work being done by Ilisaqsivik, an organization that is working to train Inuit trauma support workers in Inuktut.

Nevertheless, providers are not necessarily against Westernized services. Some acknowledged a desire within communities for both Westernized therapeutic services and Inuit cultural programs based on the varying needs among the population, stating, "There are individuals who prefer the Westernized way" and "The therapeutic way is not always 100% the way our clients want to go."

However, possessing Western academic qualifications may not necessarily make professionals more fit to serve Inuit. One provider referred to individuals without Western academic qualifications as "cultural support workers" and noted that they "are being recognized as the ones that communities prefer to turn to as opposed to strangers with an academic trained Western viewpoint coming in."

Beyond credentials, providers indicated that some level of cultural competency is a necessary qualification. This could range from having basic knowledge of Indigenous peoples, to having lived Northern experience, to living in the community for an extended period of time. Some providers said that communities have expressed a burden of having to educate incoming temporary workers about their practices and ways of being. Thus, for Westernized programs and services,

such as counselling, they require at minimum that staff have lived Northern experience to be hired. When reflecting on the death by suicide rates in Nunavut, one provider noted:

> It's a huge thing that I don't think people who haven't lived there or worked there just have no idea just how vast, how present that is. You know, they're happening often. I just don't think if you haven't lived there, you can't understand.

For providers of culturally relevant wellness programs, lived experience is sometimes not enough. They try to hire Inuit and Inuktut-speaking staff to ensure that community members feel comfortable attending programming. One provider noted: "We have heard from our clients that they want services from their people more so than they would someone else." They also noted that service providers should defer to "the community to identify who they trust." Another provider explained the impact that hiring simply based on cultural awareness:

> There are some Southern individuals who said 'I've done Indigenous studies' or 'I'm culturally aware or culturally sensitive to Inuit populations', but we've often witness situations where, when it comes to cultural appropriateness, a lot of Southerners sometimes don't understand their influence on community members, especially Inuit. They feel that they've been disenfranchised, they feel that maybe their literacy levels are not as adequate as a Southern person.

To minimize turnover and hire within community, one provider explained the positive hiring measure they have implemented:

> If we are going to hire, it's people that are going to reside in the community. Anybody who sends us a resume (…) they want to do six weeks in and two weeks out, we don't even look at those resumes, no matter how beautiful they look.

Some providers will go so far as to fly Inuit facilitators in from the closest community or region if they are unable to find local facilitators. They explained that it is considered harmful to have a program or service in a community for a short period of time where people begin to give trust, and then have it disappear. One provider said:

> The reason why we've chosen to go that path is our job is really to listen and the community keeps saying 'I have to keep retelling my story' and so why do we need to keep doing that practice where if we can put in the proper structure to have staff members that are going to stay in the community for a longer period of time, maybe a year or two years, that's a much better approach than doing the whole transient thing.

Another provider made a case for cultural programs where short-term hiring practices can be detrimental:

> But a lot of people do seek Western-style support in mental health. I think in Iqaluit, there's not a lot of mental health resources, and there's counsellors, however, they are not always available and they're only here for a small period of time. So, if you do find a counsellor or if you finally found someone that you could talk to who is a professional caregiver, it is most likely that they will leave within a period of time and you will be left with nothing. That's why I say that cultural support for mental wellness, I find, is more impactful, because it's always going to be here. And if the person who was helping you is gone, let's say they go out of town or they pass away, there may a lot more people to give you that similar support. That's part of why we try to coordinate a bunch of culturally relevant programs.

Regardless of their hiring practices, providers unanimously expressed that their goal was to hire people from the region as much as possible, if not also Inuit, to ensure that their programs and services are attended and delivered in an effective way, regardless of the mode of delivery:

> The traditional and cultural programming, we try our absolute best that it is facilitated by an Inuit person that understands the language that understands the culture and also has a way of working with the community, especially the young people.

This is knowledge that is not gained through Western academia.

Lastly, a few providers mentioned that challenges to hiring and retaining Inuktut-speaking staff can go deeper than long-term availability, qualifications, and cultural fit. Wellness professionals themselves may be impacted by the work they do, and they need a support system to help them deal with their trauma:

> In my perspective, somebody who is a court interpreter, for example, who is used to interpreting really heavy stuff during trials, would be an ideal person for such a role because they are bombarded with the most awful translations and their infrastructure could potentially be there to support them post those interviews.

In the same vein, a few providers explained that it can be very difficult for Elders or other members of the community to offer their professional or volunteer services because they or their loved ones have likely had their own traumatic experiences. Tagalik (2010) explains that for Elders, "The harmful impacts of colonization resulted in the repression of this knowledge (*IQ*) and have made Elders wary about openly sharing, as they would have in the past" (p. 6). However, paradoxically, some are also driven to help others for the same reason. Providers mentioned how important it is to have wellness resources also available to support staff.

In this section I described challenges that mental health and wellness providers face in hiring Inuktut-speaking staff. I also highlighted approaches providers are implementing to meet the needs expressed by communities. Colonization replaced Inuit ways of life with systems and institutions, that "do not 'fit' with Inuit worldview and, in many instances, work contrary to beliefs and values of that worldview" (Tagalik, 2010, p. 4). Therefore, the efforts made by providers to adapt their hiring practices in order to value and hold local and cultural knowledge as truth, where Western approaches may treat is as illegitimate, is a form of decolonization. Adams et al. (2017) refer to such practices an *Indigenous resistance approaches* which valorize "local understanding as a legitimate source of knowledge" (p. 224). This does not imply categorically rejecting all Western approaches to mental health care, but rather centring Inuit knowledge, which is inextricably connected to language, and applying Western approaches were beneficial to and requested by a community (Fellner, 2018).

In the next section, I will address the role that funding plays in helping mental health service providers meet the needs of Nunavummiut.

5.2.5 Decolonizing funding

The providers I interviewed all indicated that improving funding models could help improve access to services in Inuktut. This includes not only the sum allocated, but also the guidelines for using it as well as application and reporting cycles.

Although organizations receive funding from both the territorial and federal governments, this funding is seldom sufficient to ensure the sustainability and quality of programming. One provider explained: "Our main funding is from the GN, and sometimes we get donations. We apply for small funding from other organizations in the community." Donations were reported as one of the primary sources of funding for some providers, over and beyond government funding.

Some providers are able to secure more significant funding if they meet a need that has been deemed a “need” by the government, such as treating fetal alcohol syndrome or sexual abuse. They have observed as well that a lot of funding is given to programming in Iqaluit whereas the attitude toward programs in smaller communities is “we will get to you when we get to you.” It can therefore be challenging to provide services or programming in the domains not identified as a priority by the government or in smaller communities which do not possess the infrastructural or material resources.

Beyond the amount received, complex funding guidelines can create confusion surrounding provider roles and responsibilities, thus resulting in gaps in services for those most in need, as reported by one of the interviewees:

> Where some of the other gaps in services are is let’s say we have a 40-year-old that is potentially having some suicidal ideation. We have often witnessed a time where the different government organizations are like “our funding doesn’t support this part of the services” so what we often see is that clients, especially Inuit, are often left, they often get pawned off to so many different departments that in the end I think they just get more frustrated and they don’t get the actual help that they need. And living in a community where we know that we work with individuals who are vulnerable and have imputed colonial impacts on them, and some of these challenges that communities are facing, when time comes for them to get help, it’s almost non-existent and it’s almost like no organization wants to take the lead in helping such people. I think that’s one of the greater issues we have in the community, nobody wants to take the lead.

Further, strict policies on the use of government funding can sometimes be a barrier to hiring Inuktut-speaking individuals as they may not meet the outlined criteria. For example, there can be

specific rules, surrounding what kind of professionals can be hired using that funding. Criteria is most often based on Westernized credentials, such as an undergraduate degree from a government-recognized academic institution. This means that community members or Elders with cultural knowledge who may be available to support individuals in Inuktut cannot be compensated using government funding—perhaps meaning that they may not be compensated at all. One provider noted that "Some of the parameters around the qualifications required to be able to use specific pots of funding can be re-evaluated."

Year-to-year funding models are deemed to be less ideal because they represent significant administrative burdens, i.e., applications and reporting, for short-lived benefits. This model means that some providers are required to hire on a term or contractual basis because they are unsure of whether they will be able to pay staff from one year to the next. This hinders hiring because temporary positions are much less attractive. Further, short-term staffing does not allow practitioners to create a trusting and sustainable relationship with clients throughout their healing process. One provider emphasized that "Programming that is like a start and stop project, it does a lot of harm than any good." Hence, multi-year funding models would reduce administrative burden and allow for sustainable programming, where community organizations can properly compensate and retain staff. This would also help ensure they could plan concretely for language provisions for their initiatives.

To improve access to services in Inuktut, providers suggested that targeted funding toward increasing language competency in English-dominant communities would go a long way. Likewise, specific funding for language provisions within existing service offers would help organizations provide interpreters on a more systematic basis. One provider said: "It would be easier to have that kind of money to always have a translator and to always have an interpreter."

One provider also suggested that more clarity surrounding roles as well as increased collaborative efforts could also make a difference:

> We know that funding levels are sometimes challenging, but I think in situations where the different government organizations are really working together, in the long-term it will be able to help the majority of the population.

Thiong'o (1992) notes that "Imperialism is total: it has economic, political, military, cultural and psychological consequences for the people of the world today" (p. 2). This means that imposing Western standardized funding models on the organizations that serve Northern communities is in fact a form of colonizing practice which harms those who are supposed to be benefiting from the services offered (Adams et al., 2017). Hence, decolonizing funding would entail challenging those standardized funding models that perpetuate colonial knowledge and understanding, and empowering Inuit through envisioning modes of financial support that would allow for programs that they themselves believe will best benefit their communities.

In the next section, I will highlight the importance of decolonizing discourse to ensure mental health services and programs are utilized and benefited from in Inuit communities.

5.3 Decolonizing discourse

When beginning this study, I did not intend to analyze discourse in my data. However, during my document search, I noticed subtle distinctions between the terminology used on the websites of Westernized mental health service providers and those of community providers. To validate my observations, I selected one webpage from each provider that outlined the services they offer. I then created two-word clouds in NVIVO 12, one with the pages of Westernized providers, and the other with pages from community providers.

Figure 4: Western providers

Figure 3: Inuit providers

In the figures above, there are some words that are equally prominent, including *support*, *mental*, *program*, and *service*. However, other words are more prominent in Figure 4 (Inuit providers) than in Figure 3 (Western providers), such as *community*, *help*, *cultural*, *wellness*, and *violence*. Other words that appear among Inuit providers do not appear at all among Western providers: *learn*, *knowledge*, *traditional*, *babies*, *life*, *abuse*, *healing*. Conversely, the words *Indian*, *professional*, *emotional*, *suicide*, and *residential*, which are used by Western providers, do not appear in among Inuit providers. One pattern that was not detected in the word clouds is that *IQ* principles—the foundation upon which Inuit well-being is conceived (Tagalik, 2010)—used on Inuit provider pages are never translated, regardless of the page language, but may be accompanied by an explanation in English.

Rather than to place judgment on the patterns I was seeing, I decided to ask a few participants about how they went about choosing words to present services on their websites. It is important to note that our conversations about linguistic decisions surrounded the English language versions of their websites only.

When speaking to providers I noted that the language they used while describing to me their practices was different than the text on their websites. As an example, I asked them whether they

would use the term "group therapy," as it appeared on their website, to advertise services in their community. They responded:

> We try to stay away from words that can stigmatize programming. If they hear "therapeutic" that can be very triggering. If they see "counselling," any words like that, it kind of deters people from coming to attend programming. But if we say "healing," if we say something that doesn't scare them away, it helps to draw them in.

Recall that the word "counselling" appears as a prominent word in Figure 3, Westerner providers. It is possible that certain terms tell community members whether the type of service being offered is Westernized versus Inuit, and some are deterred by it. One provider shared that "circle of support" or "empowerment night" would be more effective in drawing people in.

One provider offered a concrete example by referring to the consultation process for Nunavut's new Mental Health Act (2021), noting that it was communicated using the words "consultation" and "mental health," which was ineffective in getting community input: "the majority of the population doesn't even know what you're talking about." Another provider clarified that "The English language can be very complex and we want to make sure that we are using words that the average person on the street can understand."

Multiple providers also mentioned that considering imagery and other graphical elements is especially important when using English. For example, when making a promotional video in English, actors must still be Inuit. The following was noted with regard to posters:

> We do it in a very common, a very understandable language. And we also do it in bright bold colours, it draws people's attention. (…) If we are doing a poster, for example, there's no way we're going to put a poster with green grass in the background or even to put trees.

> We put something like the tundra and that communicates more than putting big trees and tall buildings.

The significance here is that much of Nunavut is tundra, meaning that it has no trees; the ground is bare and rocky, with patches of shrubs, mosses, and other low vegetation. Understanding of the physiographic regions of the territory is essential knowledge in communicating with people who consider *avatittinnik*, "respect and care for the land, animals and the environment" (RCYNU, 2021), to be a core societal value. Thiong'o (1992) alludes to the importance of discourse when he describes colonial language as a "carrier of culture" (p. 17). He explains its impact on the colonial child as follows:

> Since culture does not just reflect the world in images but actually through those very images, conditions a child to see that world in a certain way, the colonial child was made to see the world and where he stands in it as seen and defined by or reflected in the culture of the language of imposition. (p. 17)

When asked how they market their services, providers mentioned the telephone, social media (primarily Facebook), word of mouth, and posters. Word of mouth is still one of the most reliable ways of ensuring that people are aware of the availability of a service. When staff members travel to the communities, whether for work or personal reasons, they tend to take posters or brochures with them, or simply tell people about what is available to them. Another practice mentioned was sending out letters to local organizations to inform them of services as well as seek support in communicating the services to their respective regions. Since access to Internet and computers vary from one community to another, unconventional means of communication are also used: "Sometimes it's sending the poster via text message. A lot of people have cellphones and it works out."

For some providers, I learned, websites are a formal tool that they use to communicate and report on their programs to the general public or to sponsors and partners rather than the beneficiaries of their services, for instance:

> Our website is definitely something that is managed by our senior headquarters (...) and they go through a whole communications process to populate and create the copy for that. So it's a little more bureaucratic and not everyone is comfortable accessing that online.

Websites, which were among the only documents I had access to during my first stage of data collection, are thus not the prime vehicle of communication with those in need of support. Providers have other, more informal discursive practices that are tailored to their reality, and that often occur in Inuit Language.

Unfortunately, as shows the existence of websites in English, although some providers may be Inuit-owned and operated, as well as Inuktut-speaking, they must still possess the Westernized knowledge and practices required to receive support and funding from Westernized institutions. The need to construct a website in a way that enables funding goes hand in hand with restrictive funding models and points to a neocolonial capitalist hierarchy, where those in power are the same as those with capital and those that determine who gets assistance and under what circumstances. As Thiong'o (1992) explained, colonialism ultimately sought to control wealth, however, this could not happen without simultaneously devaluing the culture of its victims and elevating the language of the colonizer.

Another discursive practice that called my attention was the use of the word "Canada." In fact, all six national services retained in my data either have "Canada" in their name or explicitly indicate that their services are available to "anyone in Canada" or "across Canada." However, only one of

them, the national helpline for Indigenous peoples, had indications of services in any Indigenous language. This presents a number of questions surrounding the concept of othering. If there are multiple national helplines and services, but only one provides for Indigenous languages, does that mean that the other services do not consider Indigenous peoples to be part of their clientele? These services that are available "across Canada," are only available in *colonial* languages. Service availability at the federal level can be thus inextricably linked to language status. This is an example of normalized coloniality, not because there is a dedicated helpline for Indigenous peoples, but because the services that are for "Canada" are only really available to those who accept to be colonized and be helped according to Western definitions and by Westernized means. The consequence of refusing assimilation, then, is to be othered.

Tulloch et al. (2018) explain that "Whether in everyday conversation or in official texts, discourse can be a snapshot of a current society and an echo of its past, as well as a vehicle for perpetuating or challenging ideologies and behaviors" (p. 241). In this section I showed that providers indicated that the presence of certain Westernized discourse among mental health providers may deter Inuit from accessing services, because it is triggering or may provoke feelings of fear. As research has found (Chen et al., 2009; Kim et al., 2011; Sentell et al., 2007), even when mental health services and supports exist, there can still be reluctance on the part of some populations to access them. Therefore, by decolonizing discursive practices surrounding mental health (in English), Western providers would be facilitating access to their services for English-speaking Inuit.

CHAPTER 6: CONCLUSION

6.1 Study contributions

The objective of this thesis is two-fold: first, to explore language policies within organizations that provide mental health services and supports to Inuit in Nunavut; second to conduct this study through a decolonization lens. I conducted a document review of language policies within mental health institutions serving Nunavut. I supplemented this review by six semi-structured interviews with representatives of organizations. Decolonization served as both my conceptual and methodological frameworks under the broader umbrella of language policy and planning (LPP).

This research demonstrates that language is recognized as an integral component of Inuit wellness in many spaces, but that service providers face systemic challenges in systematically offering Inuktut services to communities in Nunavut. The fact that these challenges are systemic means that they are not isolated, but rather interrelated. My data corroborates earlier findings that the dominance of English in urban contexts in Nunavut is neither a coincidence nor an accident. It is a product of subtractive colonial language policies of the past (Griffith 2017; TRC, 2015) and present lack of opportunity to speak the Inuit Language in society (or perhaps its stigmatization) even when receiving essential services (ITK, 2021; Office of the Languages Commissioner NU, 2015). However, this is not because there is an actual lack in the number of Inuktut speakers in the territory, rather a lack of Inuktut-speaking employees in these spaces. According to the data collected in my project, Inuktut-speaking individuals face barriers to employment in mental health based on Western qualification standards, which are also woven into criteria for funding. Moreover, where services could be facilitated by interpreters, they may not meet Western qualification standards and are thus not compensated for their knowledge, or community organizations simply cannot afford to pay them, regardless of credentials. While Western

qualifications are meant to protect mental health service beneficiaries, research indicates that language and culture are the most important protective factors in Indigenous communities (McIvor et al., 2009), in addition to being social determinants of Inuit health (NCCAH, 2012). There is also a difference between Western conceptualizations of safety and those of Inuit. Thus, as Adams et al. (2017) and Bhatia (2020) indicate, and as seemingly confirmed by the data collected for this project, assuming universal application of Western knowledge, policies and practices can be harmful to communities who do not share in these ways. To this, I add that this universal application in the Canadian context causes *systemic* harm. It is systemic in that study participants linked difficulties in providing mental health services in the Inuit Language to hiring policies, which are in whole or in part dependent on funding policies. It is demonstrated in the concerted efforts being taken at the community level to resist these challenges, which have neither been officially identified nor reported upon in government or academic literature—i.e., at the system level.

To remedy these challenges, providers shared a wealth of information about how language could be used to break away from the systemic barriers in order to decolonize mental health services. First, some providers mentioned a need for more officially bilingual (Inuktut/English) programs with bilingual facilitators who understand Inuit culture and can capture meaning well in both languages. Second, staffing challenges could partially be remediated by tailoring funding models to acknowledge the specific reality in the territory and allow for Inuit wellness models, such as land-based programs and community workshops. Lastly, providers demonstrated how even the use of English could be decolonized so as to encourage people to join the programs and use the services available. For instance, certain words that are used in Westernized mental health spaces, particularly “counselling” and “therapeutic” or “therapy,” are triggering and deterring to Inuit due

to colonial oppression and forced assimilation. These could be replaced by words like "healing", "support", and "empowerment". This practice also extends to ensuring that the graphical elements accompanying the text are culturally coherent in each community. Finally, the vehicle through which services are communicated is critical. Word of mouth, Facebook, and posters are the most effective avenues of communication. It is also important to know that when conveying information in person in a community to which one does not belong, particularly as a settler and/or employee of the government, respect for community ways of knowing, doing and being as well as humility in seeking their trust come first and foremost.

My data highlights that if funding and other forms of support are not flexible enough and fully accessible to organizations who possess the local knowledge necessary to help their communities, then neocolonial power dynamics are perpetuated under the guise of (white) saviourism, where "the spectacle of the sufferer elides the complex structures that produce their suffering" (Jefferess, 2021, p. 423). Saviourism ought not to be conflated with reconciliation. Saviourism is to create a system of qualifications which only Western organizations and practitioners can meet and to then lament that those qualified unfortunately cannot provide culturally and linguistically appropriate services despite their best efforts. In face of these realities, decolonizing mental health provision would be to centre cultural knowledge and language as principal qualifications and then train said individuals/organizations to apply any Western techniques that their communities deem useful. Indeed, the providers interviewed demonstrated that they are not in need of saving, but rather empowerment. As testified by the study participants, the de facto policies and holistic solutions designed by Inuit organizations to simultaneously encourage wellness, relationship and language within their programming demonstrate that Inuit are capable and possess the knowledge to design systems to the benefit of their communities which go beyond Western imagination.

6.2 Study limitations

The scope of this study is limited regionally, representatively, and temporally. First, it is limited to examining language policies of mental health providers serving Inuit in Nunavut only, as opposed to others who may provide for the Inuit Language in all of Inuit Nunangat or beyond. Second, because this study is exploratory in nature, I did not conduct a scoping review, nor provide an exhaustive list of all mental health programs in Nunavut, nor examine in depth the actual outcomes of the policies studied, but rather limited my project to overview programs which receive support from the federal or territorial government. Similarly, interview participants were representative of only six providers out of the 22 who met the criteria. However, this does not negate the quality and validity of information shared by interviewees, which provides in-depth analysis of the realities they are facing, and largely addresses questions from a systemic and cultural standpoint. Lastly, the results presented in this study are limited to a specific period in time. There has been a substantial increase in funding for mental health programming for Inuit in the wake of the COVID-19 pandemic, and thus a growing number of new providers, services and supports that may have come into existence or been modified during the writing of this thesis. This time limitation notwithstanding, the data provided in this thesis does represent the state of language policies and practices among mental health providers after the onset of the pandemic.

6.3 Study implications

The results of this study demonstrate that there are important questions to be asked surrounding how institutions provide for the Inuit Language in the context of mental health. They paint a portrait of how language policies and planning can have an impact on the effective provision of mental health programs and services. They contribute to the argument that, in accordance with its official status in Nunavut, Inuit Language policy considerations should become an integral part of

service provision, hiring protocols, and funding design processes, as well as data collection strategies. Unlearning, dissecting, and redesigning through co-design (with Inuit) are all necessary.

At the system level, Nunavut's distinct land, language, and people should be accounted for in both policy and communication practices. As demonstrated by my data, it is important to know the history and current reality of the community being served, whether they may be hesitant to trust due to past experiences, whether they speak one or more Inuktut dialects, whether they prefer Westernized or Inuit-specific forms of care. This information determines what type of wellness programs to deliver, who should deliver them, and what knowledge and skills they should possess. Based on the reflections of study participants, local people possess much of the knowledge necessary, but face barriers to employment. Thus, there is much work to be done to enable sustainable local hiring. This includes ensuring that wellness practitioners themselves have access to support and training.

In the same vein, frameworks for funding wellness programs in North should be designed alongside or based on the standards of care outlined in human resource policies. This is so that when providers, like the ones mentioned in this research, implement hiring policies that promote retention and stability, they are supported systemically by the funding they rely on. Further, designs must include economic benefits for those who possess the cultural and linguistic knowledge and skills necessary to serve this society. This could mean providing enough funding for professional interpretation services, or for ad hoc honorariums for Elders, employees, and other volunteers who provide unofficial services. If we are passive about language policy in any space, then the same patterns that hinder vitality and revitalization will continue.

In the field of LPP in Canada, there is value in addressing First Nations, Inuit and Métis as distinct peoples rather than as an Indigenous whole. Inuit in Nunavut live in specific contexts that may not

necessarily exist elsewhere. For example, Nunavut is a tundra, Inuit have a distinct knowledge system (*IQ*) which is not shared by First Nations or Métis and of which language is an integral part, and the Inuit Language is supported by a legislative framework, unlike other Indigenous languages in Canada. My study demonstrates that each of these elements, in addition to the invaluable knowledge of providers at the community level, should be considered when seeking to effectively design or optimize mental health services for Inuit in Nunavut in a way that centres language and culture as part of the healing process.

Lastly, it would be counterproductive to work on decolonizing any system without also doing so at an individual level. Decolonizing is a continual undoing, within self and systems. This includes challenging conventions of knowledge, listening to and amplifying non-Western voices, and reassessing the conceptual frameworks to which we subscribe.

6.4 Future research

There is little to no research that examines connections between language and mental health services in Nunavut, hence a variety of useful research projects could be envisioned. Considering my findings, it may be worth exploring these same or similar research questions in all of Inuit Nunangat. A complementary avenue of research could also be to examine how community members themselves experience mental health services with respect to language. This would help validate direct correlations between language of service and effectiveness of service.

In June 2021, the Nunavut's new Mental Health Act received assent from the Commissioner of Nunavut, the Honourable Eva Qamaniq Aariak, who also served as the first Languages Commissioner of Nunavut. Whether a happy coincidence or other, the territory's official languages are well accounted for in this new legislation. It will thus be very interesting in the near future for

research to examine whether the status given to Nunavut's official languages in mental health legislation will impact provider de jure and de facto language policies in mental health programming.

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