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**Abstract**

This paper will be of interest to anyone concerned with a critical appraisal of mental health service users' and carers' participation in research collaboration and with the potential of the post-colonial paradigm of cultural safety to contribute to the service user research [SUR] movement. The history and nature of the mental health field and its relationship to colonial processes provokes a consideration of whether cultural safety could focus attention on diversity, power imbalance, cultural dominance and structural inequality, identified as barriers and tensions in SUR.

We consider these issues in the context of state-driven approaches towards SUR in planning and evaluation and the concurrent rise of the SUR movement in the UK and Australia, societies with an intimate involvement in processes of colonisation. We consider the principles and motivations underlying cultural safety and SUR in the context of the policy agenda informing SUR.

We conclude that while both cultural safety and SUR are underpinned by social constructionism constituting similarities in principles and intent, cultural safety has additional dimensions. Hence we call on researchers to use the explicitly political and self-reflective process of cultural safety to think about and address issues of diversity, power and social justice in research collaboration.

**Keywords**

Cultural safety, diversity, research, power, service users/consumers, carers, mental health,

## Introduction

The paper offers a critical appraisal of the participation of mental health service users in research collaboration and the potential of cultural safety to concentrate researchers' attention on power imbalance<sup>1</sup>, cultural dominance and structural inequality<sup>2</sup> informing research practices and mental health service users' experience. According to Kara the literature on mental health service user<sup>3</sup> research involvement 'suggests that power imbalances and identity issues are at the root of most difficulties and gaps' (Kara 2013, 122). Kara suggests that these matters relate to the diversity<sup>4</sup> of players in mental health research, which, along with service user involvement, is central to policy in both the UK and Australia (Australian Health Ministers 2010; HM Government 2011a; HM Government 2011b). Diversity concerns are evident in the work of the UK's Mental Health Research Network (NHS National Institute for Health Research 2013) and of a proposed Australian National Mental Health Consumer Organisation (Craze 2010; also see <http://mhconsumer.org.au/>).

These similarities between the UK and Australia reflect their close socio-political relationship and shared history in colonial projects and so they were chosen as the context for our discussion. Today both societies grapple with control of bodies, minds and discourse in

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<sup>1</sup> Power is a contested concept in deep, ongoing philosophical debates. We are indebted to Berger and Luckmann's (1966) social constructionism that overcame the agency [Weber] and structure [Marx] debate in arriving at a concept of power that recognised it as an aspect of social relationships occurring in the dialectic between individuals and structures.

<sup>2</sup> By structural inequality we mean systematic unequal rewards, access to resources and their control, and opportunities in education, health and so on that are a consequence of social processes and relationships experienced by groups such as mental health service users.

<sup>3</sup> We use the term service user to refer to mental health service consumers and carers. Various other terms are used in the UK and Australia, e.g. people with lived experience, consumer, carer and survivor. We use the term SUR to denote the movement advocating their involvement in research.

<sup>4</sup> Our use of the term diversity refers to social experience related to ethnicity, gender, gender identity, sexual orientation, physical and intellectual dis/ability, age and socio-economic status.

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3 increasingly complex societies created through globalisation and colonial diasporas. As Bell  
4  
5 and colleagues note: 'As Europeans expanded their borders, the cultures, peoples and  
6  
7 diseases they embraced began diffusing through permeable membranes back towards their  
8  
9 imperial cell bodies' (Bell, Brown and Faire 2006, 589).  
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15 The resultant health inequity, poverty, stigma and racism (WHO 2010) are of concern in  
16  
17 Australia and the UK. Unsurprisingly these processes impact on mental health and problems  
18  
19 are compounded since service users experience discrimination and victimisation, poorer  
20  
21 health outcomes, and barriers to work, education, the practice of their civil rights and  
22  
23 wealth creation (WHO 2014). These structural inequalities reflect and entrench the unequal  
24  
25 power relations experienced and constitute the cycle of disadvantage that the mental  
26  
27 health SUR movement sought to overcome.  
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33 We reasoned that cultural safety, a philosophy and approach to clinical nursing, nurse  
34  
35 education and research that focuses on these concerns should be central to this  
36  
37 conversation. Further as a specifically 'postcolonial paradigm of inquiry'<sup>5</sup> (Racine 2009, 183)  
38  
39 it is directly relevant to the mental health and social problems arising from colonial activity,  
40  
41 related to what Joseph aptly calls the '... colonial ancestry of psychiatric violence' (2014,  
42  
43 275). Therefore we suggest that cultural safety with its focus on social justice and its  
44  
45 challenge to mainstream cultural dominance in research practice and ways of knowing  
46  
47 should be integral to mental health service provision, evaluation and research and conclude  
48  
49 that it is a useful model to support SUR.  
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57 <sup>5</sup> Note that Ramsden used the term neo-colonial in preference to post-colonial as she saw these power relations as continuous, so post-  
58 colonialism had not been achieved (2002, 1).  
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3 To ground the discussion we start with an introduction to cultural safety and its definition of  
4  
5 culture that inverts diversity concerns by challenging where the locus of diversity problems  
6  
7 should be. We then move on to an overview of SUR in its historical context, since state-  
8  
9 driven policy approaches to service user inclusion in the UK and Australia, developed  
10  
11 concurrently with it. We consider debates about the value and outcomes of such research  
12  
13 processes in terms of power sharing and control of research practices in both contexts.  
14  
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18  
19 We then turn to a discussion of calls for cultural change in SUR and the potential of cultural  
20  
21 safety to bring it about. We consider the role of cultural safety to confront power  
22  
23 imbalances as the SUR movement struggles to achieve its aspirations within predominantly  
24  
25 state-funded mental health research. Importantly the context of this struggle is policy  
26  
27 focussed on individualism and the reduction of human services to market forces, a form of  
28  
29 cultural dominance obscured by government policy and rhetoric of inclusion and  
30  
31 participation.  
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### 38 **Cultural safety: introduction to the concept**

39  
40 Cultural safety was developed with the Maori community by Maori nurse scholar Irahapeti  
41  
42 Ramsden in the 1990s, in the neo colonial context of New Zealand (1991; 2002). It aimed for  
43  
44 cultural change by exposing and addressing power imbalances to decrease the impact of  
45  
46 cultural dominance and racism in health care, education and research (McClelland 2011).  
47  
48

49  
50 Ramsden was motivated by nursing curricula devoid of structural issues and designed by and  
51  
52 for those who did not share her cultural position or experience of colonisation. She wanted  
53  
54 to challenge this form of cultural dominance and the way it shaped policy and developed  
55  
56 nurses as mere biomedical technicians rather than agents of social change (Ramsden 2002).  
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5 Ramsden saw cultural safety as a way for nurses to consider how their socialisation and  
6  
7 cultural position impacted on their work. She emphasised the links between ill-health and  
8  
9 dispossession, economic status and political agendas, as against individualist biomedical  
10  
11 notions that illnesses merely occur within bodies. Further, she argued that transcultural  
12  
13 approaches focussed on the “cultural” activities of patients, based on the idea that culture  
14  
15 simply means ethnicity and that culture is, therefore, unchanging. As a consequence,  
16  
17 transculturalism promotes stereotypical views of culture and limits nurses’ responses to  
18  
19 diverse social experiences and positions (Ramsden 2002, 112).  
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26  
27 In contrast cultural safety is underpinned by social constructionism so proponents accept  
28  
29 that people create society and in turn society influences human activities too. In cultural  
30  
31 safety, culture is conceptualised as changeable, learned, strategic and socio-political and ‘...is  
32  
33 used in its broadest sense to apply to any person or group of people who may differ from  
34  
35 the nurse/midwife because of socio-economic status, age, gender, sexual orientation, ethnic  
36  
37 origin, migrant/refugee status, religious belief or disability’ (Ramsden 2002, 114). In cultural  
38  
39 safety these differences are accepted and respected as legitimate not as deficits to  
40  
41 dominant norms.  
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48 Although these issues and aspects of cultural identity are the dimensions of diversity that  
49  
50 policy in the UK and Australia seeks to address in the mental health field (see Australian  
51  
52 Health Ministers 2010; HM Government 2011a) cultural safety challenges the dominant  
53  
54 conceptualisation of diversity’s significance in two respects. Firstly, under cultural safety’s  
55  
56 definition of culture, diversity does not belong to people of colour or those who differ in  
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3 some way or other from mainstream culture. Dyck and Kearns (1995) discuss one of its key  
4  
5 concepts, bi-culturalism, which, although subject to some criticism (Reimer-Kirkham et al.  
6  
7 2002; Harrowing et al. 2010) signals that *everyone* has culture.  
8  
9

10  
11  
12 This point is important since discussions about health inequality are often dominated by a  
13  
14 'white' cultural position where culture and ethnicity are seen as only belonging to so-called  
15  
16 Culturally and Linguistically Diverse (CALD)<sup>6</sup> 'others' (Tolich 2002; Cox and Taua 2013),  
17  
18 positioning the source of social inequity firmly outside white mainstream domains. Cultural  
19  
20 safety however requires that health care professionals and researchers accept that they are  
21  
22 bearers of culture; that they are socially powerful, privileged and positioned; that their  
23  
24 status is related to historical and political processes; and that it is their own values, beliefs  
25  
26 and assumptions that require examination to shift power relations and structural  
27  
28 inequalities.  
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36 Secondly then, the significance of culture and diversity is not differences in ethnicity, in art,  
37  
38 ritual or ceremony, but in how people are treated differently in everyday life as they deal  
39  
40 with social institutions such as health/welfare, businesses, media and educational  
41  
42 institutions. In this respect cultural safety resembles mental health service users'  
43  
44 perspectives that health professionals should ask them 'what happened to you' not 'what is  
45  
46 wrong with you' (British Psychological Society 2013).  
47  
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51  
52 Being grounded in critical social theory, cultural safety recognises that health service  
53  
54 delivery, education and research are not value neutral activities but reflect the values,  
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57  
58 <sup>6</sup> In the UK the acronym BME (Black and Minority Ethnic) or BAME (Black, Asian, Minority Ethnic) is used. Australia employs CALD and  
59 other terms such as non-English speaking background (NESB) or English as a Second Language (ESL).  
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1  
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3 assumptions and priorities of those involved and historical and socio-political contexts  
4  
5 (Ramsden 2002; Anderson et al. 2003; Reimer-Kirkham et al. 2002, 2009; Browne et al.  
6  
7 2009; Racine 2009). Unless practitioners undertake processes of self-reflection, as required  
8  
9 in cultural safety, unexamined relations of power can be perpetuated. Cultural safety  
10  
11 provokes us to ask who holds the power to define what counts as knowledge, as health, as  
12  
13 recovery or as evidence; challenging us to bring to mind cultural assumptions that 'culture'  
14  
15 and 'race' determine outcomes and blaming people for their social situation (Browne et al.  
16  
17 2009; Racine 2009; McClelland 2011; McGibbon et al. 2013).

18  
19  
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23  
24 Just as proponents of cultural safety say that it is systems that need to change rather than  
25  
26 users of such systems, so Frankham (2009), writing about service user involvement in  
27  
28 research, proposes that mainstream society is the appropriate locus for efforts at change.  
29  
30 This position, which underpins the emergence of SUR to which we now turn, is in stark  
31  
32 contrast to the neoliberal view that it is individuals who must engage in ever expanding  
33  
34 processes of self-improvement.  
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#### 40 41 **The emergence of mental health service user research**

42  
43 The 1990s saw a profound mental health reform agenda in Australia expressed in the First  
44  
45 National Mental Health Policy in 1992. Its evaluation and the development of National  
46  
47 Standards for Mental Health Services in 1997 emphasised the requirement for service user  
48  
49 involvement at all levels of mental health services (Goodwin and Happell 2006).

50  
51  
52 Concurrently in the UK there was a drive to include service users in the commissioning,  
53  
54 design, delivery and evaluation of health and social care services (Department of Health  
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3 1999a, 1999b, 2000, 2005). Thus as Barber and colleagues (2011, 609) establish, mental  
4  
5 health service user involvement, specifically in research, became expected in both contexts.  
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10 Beresford (2002) explains that these initiatives were partly in response to the growing  
11  
12 demands of a mental health SUR movement to lead and control research that was about  
13  
14 them and the issues that impacted on their lives, a process he calls the democratic approach  
15  
16 to SUR. However he reminds us that the New Right and the service users' movement did not  
17  
18 see participation and user involvement in the same way and, as Frankham argues, the  
19  
20 impetus for the SUR movement was the desire to explore the disabling assumptions arising  
21  
22 from individualism and the institutionalised disabling practices of society (Frankham 2009,  
23  
24 2).  
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31 In a similar vein to cultural safety's focus on how people are treated in society, Frankham's  
32  
33 point is that it is not diversity [e.g. gender, ethnicity, disability or age] per se which  
34  
35 dominates people's experience but how society impacts and respond to them. She discusses  
36  
37 the social creation of deficit discourses that circumscribe people's identity and social  
38  
39 experience more than the disability itself. Thus the SUR movement sought to create  
40  
41 knowledge that could explain the economic, political, cultural and environmental structural  
42  
43 drivers of these experiences and deprivations (Frankham 2009).  
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49  
50 Such concerns stand in contrast to another facet of these developments; namely a  
51  
52 consumerist approach. Far from ceding any power or control over research agendas or  
53  
54 practices to mental health service users, it is argued that '... mainstream interest in user  
55  
56 involvement in research and evaluation highlights feeding user knowledge and experience  
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3 into existing research arrangements and paradigms ... ' (Beresford 2002, 101). Further, the  
4  
5 complex dynamics of these power relations are often suppressed by discussions of  
6  
7 inclusivity and community, overcoming any concerted effort to acknowledge and actually  
8  
9 deal with diversity in people's experience, interests and needs and with the complexity of  
10  
11 knowledge production in such circumstances (Frankham 2009, 19).  
12  
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16  
17 While there are clearly worthwhile and robust benefits to researchers and service users of  
18  
19 inclusive approaches (Simpson et al. 2014) these papers highlight the broader social-political  
20  
21 influences at play. According to Beresford, mainstream state institutions include service  
22  
23 users in processes presented as inclusive, but which are motivated by the need to subvert  
24  
25 and contain threats to the legitimacy of state control over mental health policy, planning  
26  
27 and research processes that the SUR movement signified. While the perspectives of service  
28  
29 users can legitimate governments and their agencies and provide evidence of inclusivity,  
30  
31 they can also be aimed at 'efficiency, economy, and effectiveness' and, in this process,  
32  
33 service users become available as scapegoats should such policies fail or become unpopular  
34  
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37  
38 (Beresford 2002, 97).  
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### 43 **Service User research: the state of play**

44  
45 In the decade or more since Beresford's paper (2002), concerted efforts to include mental  
46  
47 health service users in research and service evaluation are evident both in the UK (Rose  
48  
49 2003; Hodges 2005; Stickley and Shaw 2006; Wilson et al. 2010; Repper et al. 2011; Hancock  
50  
51 et al 2012; Staley 2012; Simpson 2012; Hutchinson and Lovell 2013; Simpson et al. 2014)  
52  
53 and Australia (Lammers and Happell 2004; Craze 2010; Callander et al. 2011; Hancock et al.  
54  
55 2012). But the level and nature of that involvement most often remains disappointing.  
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3 Staley (2012) overviews SUR in the UK's Mental Health Research Network concluding that  
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5 40% of projects involved service users on steering groups with variable success and impact;  
6  
7 20% at the design stage with variable impacts, and about 20% involved SURs through the  
8  
9 whole project with strong influence on the projects.  
10  
11

12  
13  
14 Staley's analysis is a far cry from the original intention of the SUR movement that service  
15  
16 users should be involved in the whole process (Phillips 2006; Beresford 2002). Hutchinson  
17  
18 and Lovell (2013, 642) observe that, despite the apparently well-established nature of SUR  
19  
20 involvement in the UK, there is not much evidence that their involvement in research is '...  
21  
22 truly an integral embedded part of statutory mental health services'. In Australia too,  
23  
24 Lammers and Happell (2004) argued that mental health consumer participation in research  
25  
26 was tokenistic while some eight years later '... genuine inclusion of consumers as members  
27  
28 of the research team remains rare' (Hancock and et al. 2012, 218.)  
29  
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36 These commentators along with Kara (2013) point to the need for a much stronger focus on  
37  
38 SUR participation from inception to dissemination of research, to be in line with the  
39  
40 philosophy of the SUR led movement in both the UK and Australia and with mental health  
41  
42 policy and expected standards in both contexts. It is for these reasons that there have been  
43  
44 calls for a cultural change in SUR involvement.  
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### 49 **Service user involvement: tensions and debates**

50  
51  
52 Appeals for cultural change in SUR involvement reflect its politicised nature and speak to the  
53  
54 problem of power imbalance. In 2006 Phillips suggested that service users had gained some  
55  
56 power and could advance their cause by lobbying, advocacy and positions of authority in  
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3 health organisations. However Frankham (2009) proposes that the central claim by  
4  
5 proponents that research partnership processes are 'empowering' relies on a concept that is  
6  
7 rarely defined much less theorised. She calls for debate on the advantages claimed for  
8  
9 partnership approaches and proposes that the political nature of SUR creates a kind of  
10  
11 closed shop preventing analysis of its actual merit. Frankham (2009) argues that the  
12  
13 combination of government policy, funding body requirements and the unarguable moral  
14  
15 rightness of including service users, militate against sound analysis of the practice.  
16  
17 Nevertheless some analysis does exist which clearly shows that power relations are an  
18  
19 enduring problem.  
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26 Frankham (2009, 13) echoed earlier commentators in calls for a 'cultural shift' to address  
27  
28 the fact that control still sits with academics. While it is reasonable to note that academic  
29  
30 researchers spent decades gaining the qualifications and skills to lead research, it is still the  
31  
32 case that major power differentials exist between the parties. A number of commentators  
33  
34 point to power imbalances that work in favour of funding bodies and the academy such as  
35  
36 devaluing service users' knowledge (Phillips 2006); service users being outnumbered by  
37  
38 academics and not leading projects (Wilson et al. 2010); funders restricting applications to  
39  
40 academics (Fothergill et al.2013) and academics using exclusionary scientific paradigms and  
41  
42 language (Phillips 2006; Barber et al. 2011). Kara (2013) provides evidence of service users'  
43  
44 being silenced; of academic researchers being able to keep private their experiences as  
45  
46 service users or carers and of the challenges of partnership research being laid solely at the  
47  
48 door of service users.  
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3 Nevertheless Wykes argues that over the past decade sound progress has been made in the  
4  
5 mental health field in terms of the ladder of participation, from consultation to  
6  
7 collaboration and then to service user led research paradigms 'where the power in the  
8  
9 relationship is reversed' (Wykes 2014, 25), although she acknowledges that evidence to  
10  
11 support this remains a 'scarce resource' (Wykes 2014, 24). Studies led by SUR Diana Rose  
12  
13 (Rose et al. 2003; Evans et al. 2012) provide support for the emergence of SUR-led research,  
14  
15 whilst standing out for their rarity.  
16  
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20  
21 Further insights can be drawn from Patterson and colleagues' (2014) widespread study of  
22  
23 SUR. It somewhat contradicts Wykes' conclusions in reporting that while most respondents  
24  
25 had positive experiences the potential of SUR involvement is constrained by experiences of  
26  
27 stigma, discrimination and tokenism. Patterson and colleagues (2014, 7) described a need  
28  
29 for '... continued attention to deep-level cultural change and development of robust  
30  
31 mechanisms to ensure timely and meaningful engagement' and a '... critical examination of  
32  
33 power hierarchies within psychiatry'. It is with respect to challenging such power hierarchies  
34  
35 to produce cultural change that cultural safety has much to offer.  
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42

43 Anderson and colleagues (2003) draw on critical theorists to argue that cultural safety  
44  
45 directs our attention to imbalanced power relations that favour biomedical and professional  
46  
47 discourses and silence other voices in research. The need for such attention is reinforced by  
48  
49 Kara (2012, 131) in her review of SUR which showed: '... that power imbalances are situated  
50  
51 between constructed group identities: psychiatrists and patients, researchers and  
52  
53 researched, and so on; perhaps even between sub-groups of MHSUs [mental health service  
54  
55 users], such as those who have been psychiatric in-patients and those who have not'. We  
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3 turn now to a brief account of the commonalities between SUR and cultural safety before  
4  
5 teasing out the contribution cultural safety can make to SUR.  
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### 10 11 **On common ground: cultural safety and SUR**

12  
13 It is clear that the SUR movement and cultural safety arose for similar reasons and both  
14  
15 drew inspiration from feminist, civil rights, emancipatory movements and critical theory  
16  
17 (Ramsden 2002; Beresford 2002; Phillips 2006; Frankham 2009; Barber et al. 2011; Hancock  
18  
19 et al. 2012; Hutchinson and Lovell 2013; Kara 2013). They were motivated by the desire to  
20  
21 bring about social change by addressing the social and emotional consequences of 'special'  
22  
23 legislative provisions applied to Indigenous people and the Mental Health Acts applied to  
24  
25 those with mental illness and the fact that their voices and experiences were either absent  
26  
27 or devalued in research, as in their everyday life. To borrow Goffman's (1963) term, both  
28  
29 movements sought to lessen the impacts of a 'spoiled social identity' related to a loss of  
30  
31 power, status and rights; in terms of racism on the one hand and stigma on the other.<sup>7</sup>  
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39 The thrust of methodological implications of culturally safe research is its strong focus on  
40  
41 challenging power imbalances so that alternative knowledges, values and ways of  
42  
43 understanding are on an equal footing to Western scientific models and such concerns are  
44  
45 evident in some accounts of SUR (Phillips 2006; Stickley 2006; Barber et al. 2011;  
46  
47 Hutchinson and Lovell 2013; Kara 2013). Likewise, culturally safe research applied to SUR  
48  
49 would support the latter's ideal to engage service users in the whole research process in an  
50  
51 equal research partnership (Wilson et al. 2010; Wykes 2014). However, although other  
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58 <sup>7</sup> There are complex cumulative impacts for those experiencing a mental illness *and* who are Indigenous or who are the target of racism or  
59 other isms (see Happell, Cowin, Roper, Lakeman and Cox, 2013) chapter 8 for a full consideration of these factors.  
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3 participatory models share many principles of cultural safety, the approaches are not the  
4  
5 same since one could use a participatory model that was not culturally safe (Wilson and  
6  
7 Neville 2009; Cameron et al. 2010).  
8  
9

### 10 11 12 **What are the implications for cultural safety to transform SUR** 13

14  
15 All research involves basic assumptions about the reasons for individual behaviours,  
16  
17 what is an acceptable research approach, where it is appropriate to publish results, and  
18  
19 so on. While these assumptions are often unstated and taken for granted, they strongly  
20  
21 influence what is actually studied and the way research is conducted. There is therefore  
22  
23 a need for culturally safe research... (Ramsden 2002, 105)  
24  
25

26  
27 Although cultural safety is recognised as an Indigenous and decolonising research  
28  
29 methodology (Smith 1999; McClelland 2011) it is applied more broadly to research practice  
30  
31 (Tolich 2002; Reimer-Kirkham et al. 2002; Anderson et al. 2003; Reimer-Kirkham et al. 2009;  
32  
33 Racine 2009; Seaton 2010; Harrowing et al. 2010; McClelland 2011) and has methodological  
34  
35 implications for the conduct of research. These implications centre around the fact that  
36  
37 research encounters reflect the diverse and shifting socio-cultural positions of those  
38  
39 involved; they are 'power-laden' (Dyck and Kearns 1995, 142). From the perspective of  
40  
41 cultural safety then, what matters most is the social experience and social positioning of  
42  
43 those involved since these influence research problems, questions, design, methods,  
44  
45 analysis, ethics and outcomes (Tolich 2002).  
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52  
53 The crux of cultural safety is that researchers undertake a process of critical reflection to  
54  
55 bring their cultural values, priorities, assumptions and social experience to mind to first  
56  
57 acknowledge and then address imbalanced relations of power and the dominance of certain  
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1  
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3 forms of knowledge. Although undertaken by individuals these processes are not  
4  
5 individualistic as they require reflection on structural position, power and privilege.  
6  
7 Therefore they could help to address structural inequality by challenging government policy  
8  
9 and priorities and their influence on topics and methods and the very conceptualisation and  
10  
11 focus of research projects. Such processes provoke a crucial change of emphasis from  
12  
13 locating the source of issues in the diversity of people to how society responds to diversity; a  
14  
15 change in focus from individualistic to systemic concerns.  
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22 A critical research practice based on cultural safety would go far beyond the transcultural  
23  
24 approach of including 'diverse' groups in recruitment and translating established research  
25  
26 instruments and information into various languages. For example cultural safety would  
27  
28 provoke reflection on which groups and languages are included/excluded and why, and what  
29  
30 such decisions say about researchers and the political and economic context of their  
31  
32 research practice. In this vein Kalathil (2008) notes that in research black and minority ethnic  
33  
34 (BME) people are often stereotyped as being hard to reach, experience racism and are  
35  
36 included minimally to show policy adherence.  
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43 Kalathil (2008) makes the observation that three decades of service user involvement has  
44  
45 seen little change in mental health services, citing these circumstances as a major barrier to  
46  
47 their being involved in service user activities. Kalathil (2008, 10) writes '...service user  
48  
49 involvement will become a meaningful reality only if the damage done to individuals within  
50  
51 mental health systems is acknowledged, and the roles and power relations between users  
52  
53 and mental health professionals ... evaluated'. Kalathil (2008, 16) discusses an intersection of  
54  
55 race and class where middle class professionals, who have the resources and willingness to  
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1  
2  
3 volunteer their time, feel awkward around black people with whom they are otherwise  
4  
5 unfamiliar. These dynamics were identified as additional barriers to BME (and, we would  
6  
7 argue, working class) involvement in SUR. Kalathil's work suggests that a culturally safe  
8  
9 approach could make a strong contribution to easing such concerns by facilitating a  
10  
11 reflection on such dynamics amongst researchers. Indeed McClelland (2011) advocates  
12  
13 starting with community protocols rather than with ready-made academic methods which  
14  
15 shows how profoundly research processes and the excluding academic paradigms discussed  
16  
17 by Barber and colleagues (2011) might change if power relations were more balanced.  
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24 Anderson and colleagues (2003) extend the applicability of cultural safety beyond  
25  
26 Indigenous and immigrant groups by arguing that English speaking Europeans also suffer and  
27  
28 experience barriers to accessing resources and services. As we have seen, cultural safety,  
29  
30 although arising from a focus on Indigenous groups and non-English language communities,  
31  
32 nonetheless considers power relations not only on the basis of ethnicity and experiences of  
33  
34 racism and colonisation but also on dimensions of age, gender, class, ability, sexual  
35  
36 orientation and so on. It considers such factors in terms of the socio-political context of  
37  
38 inequality, suggesting that cultural safety '...should have explanatory power for all of our  
39  
40 research participants' (Anderson and colleagues 2003, 210). This is particularly so since, as  
41  
42 Anderson and colleagues (2003) point out, various scholars argue against the idea that  
43  
44 'colonised' and 'coloniser', or 'whites' and 'blacks' are always opposing categories. This is not  
45  
46 only because colonial experience is nuanced with colonised and colonisers cooperating,  
47  
48 colluding or resisting in state regimes but also because these experiences dehumanise  
49  
50 everyone, regardless of where we are positioned.  
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3 In terms of research this insight challenges notions that health professionals and  
4  
5 researchers always belong to the dominant colonising 'white' culture and the researched  
6  
7 from oppressed minorities (Anderson et al. 2003; Reimer-Kirkham 2009) and binary  
8  
9 opposites of service user/academic are not sustainable in SUR (Phillips 2006; Kara 2013).  
10  
11 However such binaries are powerful, for example when BME people are pressured to  
12  
13 separate out parts of their identity (ethnicity) from other parts (service user), and silenced  
14  
15 when they raise issues of racism, being told that they are there as a service user not as a  
16  
17 member of a particular group (Kalathil 2008). Cultural safety could support SUR teams in  
18  
19 negotiating such dynamics by encouraging participants to articulate how their social  
20  
21 experience is related to structured responses to ethnicity, culture, class, gender, disabilities  
22  
23 and sexuality for example and what implications for their research might arise from such  
24  
25 endeavours (Simpson et al. 2014).  
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33  
34 Cameron and colleagues (2010) make similar points in exploring the possibility of a  
35  
36 'culturally safe epidemiology'. For example they argue that in epidemiology the practice of  
37  
38 deeming ethnicity as an independent risk factor has been discredited as 'black box'  
39  
40 epidemiology that merely homogenises diverse people on the basis of cultural stereotypes.  
41  
42 Such an approach cannot enhance understanding of the complex interplay of social  
43  
44 experience, health determinants, historical factors and power issues which inform high rates  
45  
46 of morbidity and mortality. In contrast culturally safe research requires researchers to turn  
47  
48 the research lens back to '... their own cultural assumptions and analyse critically the impact  
49  
50 their theoretical stance has on the knowledge they generate' (Cameron et al. 2010, 95).  
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3 As Browne and colleagues (2009, 171) argue, cultural safety draws attention to 'critically  
4 orientated knowledge'; their research shows '...that it is not primarily cultural beliefs or  
5  
6  
7  
8 cultural barriers that influence how people manage their health, illness or access to care'  
9  
10 but structural constraints and limits to life opportunities. So just as we saw that it is ideas  
11  
12 about disability that are disabling so too we can see that health inequality is not so much  
13  
14 about worldviews (idealised notions of the cultural beliefs of 'others'). It is how life is  
15  
16  
17 experienced that holds the keys to understanding inequality, injustice and ill health (Kelly  
18  
19 2006; Cox and Tava 2013), a research paradigm that would be a consequence of a culturally  
20  
21 safe approach.  
22  
23

24  
25  
26 Browne and colleagues (2009) offer a sophisticated analysis of the epistemological<sup>8</sup>  
27  
28 foundations of cultural safety seeing cultural safety as compatible with critical enquiry  
29  
30 concerned with human freedom and social justice. They, like Anderson and colleagues  
31  
32 (2003) and Racine (2009), draw on postcolonial feminist theory to develop what Seaton  
33  
34 (2010, 151) calls a 'critical cultural theory'. Such a theory would consider human freedom by  
35  
36 emphasising '... intersecting oppressions' (Browne et al. 2009, 168). Together these papers  
37  
38 make a convincing argument that cultural safety can help us consider whether research is  
39  
40 dominated by certain cultural agendas, views or positions and what this means for the  
41  
42 capacity of research to improve the human condition.  
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### 50 **The limitations of cultural safety**

51  
52 A limitation of cultural safety is that it draws attention to culture which can lead researchers'  
53  
54 focus away from marginalisation and oppression. However applying cultural safety's ways of  
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57  
58 <sup>8</sup> Epistemology is a branch of philosophy that studies the nature of knowledge, ways of knowing things and the limits of knowledge.  
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2  
3 thinking about culture is transformative and deepens understanding of the diversity and  
4  
5 complexity in peoples' everyday experience (Browne and et al 2009). This is an important  
6  
7 point since research shows that assumptions about race, colour, age and gender impact on  
8  
9 medical care and health (Kelly 2006; Kalathil 2008) and Tolich (2002) suggests that similar  
10  
11 dynamics apply in research.  
12  
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14  
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16  
17 For example in Australia an inverted age pyramid related to decreased life expectancy and  
18  
19 high birth rate for the Indigenous population vs. the general population, problematises age-  
20  
21 based criteria. There new immigrants too are younger than the general population while  
22  
23 longer term immigrants are older (Minas et al. 2013). Therefore selection criteria must be  
24  
25 nuanced to avoid skewed results and unnecessarily excluding sections of the population  
26  
27 (McMurray 2004; Minas et al. 2013). In another example Browne and colleagues (2009) cite  
28  
29 the case of people identifying as Canadian being assigned to 'groups' (Chinese or Asian) for  
30  
31 recruitment. A process of cultural safety could limit these problems by researchers  
32  
33 examining assumptions informing recruitment.  
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40  
41 Dyck and Kearns (1995) and Browne and colleagues (2009) question the utility of cultural  
42  
43 safety in multicultural societies, built on ideas about equality of class, opportunity and so on.  
44  
45 Browne and colleagues (2009, 169) say these ideals '...masked the historically mediated  
46  
47 unequal power relations and the dominant cultural positions' of powerful groups in society  
48  
49 which in fact go against standards of respect and sensitivity to others. This criticism is similar  
50  
51 to Beresford's (2002) about the inclusive rhetoric surrounding consumerist policy and  
52  
53 service user involvement described earlier. We argue the slippage between ideals and  
54  
55 practice, also evident in Australia, can be addressed by cultural safety since it draws  
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1  
2  
3 attention to these contextual issues and how people really experience everyday life (Cox and  
4  
5 Taua 2013). Cultural safety brings the context of suffering (the lifeworld) into view provoking  
6  
7  
8 '... us to question all of our vulnerabilities and our common humanity' (Anderson et al. 2003,  
9  
10 212).

11  
12  
13  
14  
15 As Dyck and Kearns (1995) observe, cultural safety tackles power at the level of individuals  
16  
17 with their differing histories, social status and experience and at the collective level by  
18  
19 focussing on the socio-economic and historical conditions producing health inequity. As  
20  
21 suggested, it is our view that this argument remains relevant today particularly in the UK and  
22  
23 Australia, since cultural safety encourages researchers to look at current inequity within the  
24  
25 historical context that led to it (Reimer-Kirkham et al. 2002; Seaton 2010). We would argue  
26  
27 that these aspects of cultural safety make it highly applicable in multicultural contexts such  
28  
29 as the UK and Australia where poor health, educational issues, poverty, incarceration and  
30  
31 mental distress disproportionately affect immigrant families and Indigenous families (HM  
32  
33 Government 2011a; 2011b).  
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41 McGibbon and colleagues (2013, 6) summarise the important questions provoked by a  
42  
43 culturally safe methodology: evidence according to whom; evidence according to which  
44  
45 worldview; evidence according to whose voice? These concerns, also raised by Faulkner and  
46  
47 Thomas (2002), Phillips (2006) and Cameron and colleagues (2010) get to the heart of power  
48  
49 relations in terms of epistemological considerations in research, about what constitutes  
50  
51 knowledge and how class, gender, sexuality, ethnicity and other social complexities influence  
52  
53 knowledge construction, legitimisation and translation.  
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**Conclusion**

Our discussion shows that while there has been considerable activity over decades in service user involvement in mental health research, there are a number of tensions arising from the practice. Overall our work suggests that matters concerning power, culture and social responses to diversity are only sometimes taken into consideration in such collaborations. In considering the relevance of cultural safety to the mental health SUR movement we established that they share social constructionism as the underlying theory and have similarities in principles and intent (Ramsden 2002; Kara 2012). However we found that cultural safety has a stronger focus on ongoing processes of cultural self-reflection on the part of researchers and on challenging assumptions about how knowledge is created and what counts as knowledge/evidence. Further cultural safety is historically positioned and recognises that nothing is value neutral so power imbalance, a central concern of cultural safety, informs all research and remains a profound tension in research collaboration.

It can be assumed that mental health research seeks to transform clinical practice and improve outcomes for service users and providers and in these endeavours cultural safety calls for a stronger research focus on social and structural issues as opposed to considering individuals the measure of all things. This perspective is echoed by Frankham (2009, 16) in her call for questioning whose interests are prioritised in actions on change, where there are complex and competing ideas from service users, service providers, and policy makers on what improved outcomes might look like. We argued that since cultural safety is a specifically 'postcolonial paradigm of inquiry' (Racine 2009, 183) it is an apt approach given that many mental health and social problems are outcomes of colonial activity.

Globalisation along with colonial processes has resulted in people from many nations and

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1  
2  
3 communities being dispersed all over the planet. The resulting health inequity, social  
4  
5 marginality, poverty, stigma and racism are of central concern in Australia and the UK as  
6  
7 elsewhere. These circumstances raise many questions and suggest the research agenda also  
8  
9 needs to focus on underpinning social determinants of health inequalities as required in  
10  
11 culturally safe research, rather than sticking plaster responses to its symptoms and feeble  
12  
13 attempts to heal.  
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20 In discussing cultural safety and the quest for new ways of knowing, Anderson and  
21  
22 colleagues (2003, 213) are '...arguing for a scholarship that will transcend our tribalism, and  
23  
24 that will open up the space for dialogue that will move us closer to transformative practice.  
25  
26 The concept of cultural safety... holds promise, we believe, for opening up such a space'.  
27  
28 Likewise we see cultural safety as crucial in locating research practice in the socio-political  
29  
30 settings where it takes place, in bringing about critical reflection on the part of researchers  
31  
32 and in advancing equity and social justice (Browne et al. 2009). We conclude therefore that  
33  
34 it is an important and widely applicable model to bring about the kind of cultural change  
35  
36 that commentators call for in service user research collaboration, in terms of power  
37  
38 imbalance, cultural dominance and structural inequality.  
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