Global mental health research and practice: a decolonial approach

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The global health movement is having a paradigm crisis—a period characterised by a questioning of one's values, goals, and sense of identity. Despite important advances in population health worldwide, global health and global mental health often produce and reproduce power imbalances and patterns of oppression and exploitation that perpetuate the current modern world system (ie, Eurocentric, capitalist, and patriarchal) and its entangled global hierarchies (eg, gender, economic, epistemic, and linguistic). A consensus is emerging to decolonise global mental health, but it is not clear how to move from rhetoric to action. In this Personal View, we aim to share our experiences and the practices developed in the context of the COVID-19 health care workers (HEROES) Study. To do so, we present our HEROES decolonial team approach, which comprises three underlying principles: epistemic justice, pragmatic solidarity, and sovereign acts. We have developed decolonial team practices such as co-creating communication spaces to foster horizontal and equitable dialogue, locating and managing the study database in Chile, and ensuring local teams' rights and access to the data without barriers.

Introduction

The global health movement[1] is experiencing a paradigm crisis—a period characterised by a questioning of one's values, goals, and sense of identity.[2] This crisis is largely due to the acknowledgment that, despite important advances in population health worldwide, there is a deeply troubling issue at the very core of global health broadly, and global mental health more specifically. Currently, global mental health often produces and reproduces power imbalances and patterns of cultural, political, gender, and economic oppression and exploitation by dominant racial or ethnic groups,[3–6] which perpetuate the roots of the current modern world system (ie, Eurocentric, capitalist, and patriarchal) and its constitutive entangled power structures and hierarchies (eg, gender, economic, epistemic, linguistic, or spiritual).[7–8] This imbalance means that other world systems and world views are dominated by this global and totalising world system,[7] including global mental health. Some examples of how these power imbalances are reproduced in the context of academic global mental health are the use of covert or implicit violence and marginalising behaviours to undermine the knowledge and skills of staff from low-income and middle-income countries (LMICs) and to retain power and decision making in high-income countries (HICs);[9] requirements by funding agencies that limit LMIC institutions' opportunities to apply for or manage grant applications;[10] or, as Naidu[11] asserts, the advanced denial of the work of women of colour from LMICs by "framing [their] scholarship as illegitimate". Such examples are behind the growing recognition of this coloniality of global mental health and the emerging consensus to decolonise the field to address the fundamentally unequal power relations that hinder its transformation.[12–15] Coloniality can be defined as the persistent patterns of power originating from colonialism.[16] We use the term coloniality to refer to the underlying hegemonic logic of this world system, not to be confused with the political system of colonialism, which is sometimes used interchangeably.[7,17] Therefore, we use the term decolonial to emphasise practices, the ultimate goal of which is to dismantle the hegemony of this world system and more specifically the coloniality of global mental health. However, although recognition is a necessary first step, it is not enough for building better, decolonial versions of global mental health research and practice. Furthermore, it is unclear how to move from rhetoric to action and transform into reality what today remains a sketch of a dream.[3,6,14–15,18]

One specific way to achieve decolonial global mental health is to engage in equitable collaborative initiatives between people in and from LMICs (ie, South America, the Caribbean, Africa, and Asia) and HICs (ie, the USA and Europe) on the basis of the equal worthiness of each other's knowledge and contributions while acting accordingly. This action is not easy as individuals and institutions in the USA and Europe continue to reproduce coloniality by driving the decolonial narrative and efforts in ways that are ultimately ineffective.[19] For example, journals and conferences in which discussions about decolonising global health occur are mostly based in the USA or Europe and are rather inaccessible to others outside those contexts. Despite growing efforts, decolonial global mental health initiatives are still uncommon and rarely are their specific resistance approaches and team-building practices described. Furthermore, discussions around developing such initiatives sometimes revolve around issues such as imbalances in authorship, which, although important, are just one symptom of the much broader problem.[4]

In this Personal View, we aim to share our experiences and practices developed in the context of the COVID-19 health care workers (HEROES) study,[20] which we believe has allowed us to engage in a decolonial global mental health collaboration. We are a subgroup of 13 researchers and health-care workers from the larger HEROES team.

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Four of us were born in South America, three in the Caribbean, three in Europe, two in Asia, and one in Africa. Most of us were educated or currently work at academic institutions located in the USA and Europe. Some of us belong to historically and currently excluded groups (eg, women, minority ethnicities, the LGBT+ community, people with disabilities, working class, migrants, non-native English speakers, and others). Although these experiences shape our engagement in global mental health research, we do not speak for, or in the name of, any of these diverse groups. Our intention is to share our ongoing learning experiences, perspectives, and practices within the context of HEROES, including our open group discussions regarding patterns of privilege and oppression within the team (which usually occur within our team meeting and subworking groups in an organic manner),[21] as well as to use our own privileges responsibly to redistribute power[22] and contribute to dismantling the coloniality of global mental health. We will discuss our team's approach for engaging in this specific decolonial global mental health research practice, based on justice, solidarity, and equitable collaboration. These practices are not flawless, fixed, or universal, but rather the opposite: dynamic, plural, and sometimes even contradictory. Thus, understanding and openly discussing the privileges and oppressive patterns within our own team represents a key element needed for such a transformation. We hope that by sharing our experiences and reflective team approach, we can move the conversation forward as it particularly pertains to global mental health research practice and potentially encourage others to articulate their own ways of doing decolonial global mental health research.

HEROES study collaboration network

The HEROES study is a large global initiative aimed at evaluating the impact of the COVID-19 pandemic on the mental health of clinical and non-clinical health-care workers in more than 26 countries.[20] HEROES encompasses a wide variety of researchers and health-care professionals in or from LMICs and HICs in collaboration with the Pan American Health Organization (PAHO) and with support from WHO. This study includes many representative from South American countries, which reflects, to some extent, the origin and nature of the collaboration. We firstly included countries with representatives who were colleagues, professional contacts, or collaborators from previous studies who expressed interest in joining HEROES. Additionally, several countries contacted us through WHO and PAHO when we launched HEROES. We also sought to represent other global regions and contexts as far as possible by including countries such as Lebanon, Armenia, Nigeria, and South Africa.

HEROES organisational structure

The team organisational structure comprises the administrative team, the information technology (IT) team, local principal investigators, and team members. Our team approach is based on principles of co-operative leadership and learning, which, we believe, have contributed to creating an equitable working approach between investigators. The data centre for the entire project is physically located in South America (Santiago, Chile), which promotes active counterhegemonic methodological practices and collaboration in global mental health research.

The HEROES decolonial approach to global mental health research and team building

HEROES was originally conceived, developed, scaled, and led by a collaborative team of junior and senior researchers and health-care professionals from Latin America and the USA. The study is still mostly driven by these collaborators who are focused on establishing horizontal relationships (between team members) and breaking traditional hierarchies; something that would be difficult to achieve in a more standard research setting. Supervision and mentoring by senior and junior researchers have been available as needed to ensure scientific rigour and ongoing bidirectional learning. For example, supervisors contribute and share expertise in the current best practices of design and analysis, but those who are supervised bring challenging questions and ideas about how to use (or not use) these practices in a more valid and useful way within particular contexts. At first glance, this study might not look much different from other global mental health research. HEROES is in some ways like other global mental health efforts, but in other ways, it is very different. A closer look shows how resistance practices at the team building and knowledge production levels are intentionally exercised to challenge the coloniality of global mental health.

We argue that to overcome the coloniality of global mental health, research teams need to consciously engage in counterhegemonic practices aimed at resisting, dismantling, and escaping patterns of oppression to disrupt power asymmetries and transform global mental health.[12] Our discussion of these practices aims to specifically address how to do such a transformation, a question that remains somewhat elusive.[14] To do so, we present our HEROES decolonial team approach, which began as an intention but became tangible as the team worked out the collaboration. Our decolonial approach comprises three underlying principles: epistemic justice, pragmatic solidarity, and sovereign acts. In the following paragraphs we briefly discuss the theoretical background and provide specific examples for each one of these concepts (table).

Epistemic justice

Epistemic justice broadly refers to forms of fair treatment in relation to knowledge, understanding, and participation in a wide range of practices, including research.[23] Examples of epistemic injustice are exclusion and

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	Epistemic justice	Pragmatic solidarity	Sovereign acts
Definition	Fair treatment and inclusion relating to issues of knowledge, understanding, and participation in communicative practices	A tangible and material form of solidarity that aims to diminish unjust hardship and tol disrupt the structures that sustain imbalances in power	The capacity to re-image oneself and act outside of imposed norms, leading to other ways of being in the world
Main challenge	Foster fair and inclusive team structures and communicative practices among members	Make material and human resources accessible to all team members	Engage in a collaborative research effort that applies counterhegemonic practices that work for everyone
Examples of how to overcome the main challenge	Provide participatory spaces that disrupt power imbalances at the team building level by allowing for active and horizontal dialogue among equally credible knowers; develop an administrative and local principal investigator organisational structure that reflects the equitable nature of our collaboration	Share infrastructure and human resources in an equitable way to support getting the project started and sustaining it over time despite insufficient funding; put solidarity and *acompañamiento* (accompaniment) at the forefront	Foster data accessibility and equitable distribution of resources; disrupt existing power hierarchies and patterns in GMH research collaborations in which leadership is situated in HICs such as the USA and Europe
Discussion on decolonial team practices	Stakeholders, those with lived experiences, and those who have traditionally been excluded from meaning-making activities need to co-lead research efforts from their inception; research teams need to set their priorities, communication practices, and knowledge production practices on their own terms	The availability of material and human resources for research collaborations to move forward is a key component in any global mental health endeavour; however, the availability of these resources, not only for moving the study forward, but also for consciously addressing imbalances in power, poses a complex challenge; insufficient funding can pose a tangible threat as there are few resources (although we also recognise the flexibility of being able to set our own priorities instead of following a funder's priorities)	The engagement in a more fair and equitable way of doing GMH research needs to put those who are traditionally excluded at the centre, by allowing them to take the lead in the team building process; this change not only requires those in or from HICs to let go of power, but also requires those from or in LMICs to claim their responsibility in engaging in other ways of doing GMH
Examples from HEROES			
Example 1	We organise communication spaces (eg, Zoom meetings, WhatsApp groups, and telephone calls) for team members in which they can be recognised as knowledge holders and share their knowledge equitably with others; most of these communication spaces are led by early career researchers from or in LMICs, which has fostered a cross-pollination of knowledge across different cultures, research expertise, and geographical settings; the language barrier was a key issue and understanding the importance of language and how it can lead to epistemic injustices in research collaborations is not a small issue that can be solved by translation alone, because even when translation occurs, people whose main language is not English often can feel fear and a sense of inadequacy when sharing an opinion or experience, which hinders their active participation and leads to a marginalised status as a knower; this situation requires a particular sensibility and commitment from those in power positions (usually in HICs such as the USA or Europe) as it entails letting go of power in one of the most basic activities; in our case, having meetings exclusively in Spanish for Latin American and Caribbean members (and then translating the meetings and minutes to English speakers) allowed them to share their knowledge, experiences, interests, and feedback and fostered a sense of belonging as equal and legitimate producers of knowledge	Our infrastructure and human support for the development and maintenance of the database is physically located in Chile; this was in part because Chile had the available resources, but it also responded to the team's guiding principle of disrupting traditional hierarchies within GMH research and practice	We ensure that each local team has the right to access their collected data without barriers; local teams decide how to disseminate their data, for example in academic journals or through reports, guidelines, and the development of interventions tailored to their settings
Example 2	Initially, the administrative team in HEROES was not gender balanced; after several members shared their views about the poor gender diversity, the administrative team was reorganised and now includes two additional female members; most of the subcommittees are led and co-led by early career female researchers; more representation from gender diverse populations and those at the intersection of other marginalised identities (eg, race and ethnicity) is still needed	The Chilean and Colombian team leads the entire database cleaning and makes the data available and accessible to every local team; the Brazilian team provided support to the Czech Republic team's grant application; the Spanish team shared financial support from a grant to cover the Chilean database management work expenses	Team members from or in Latin America, the Caribbean, Africa, or Asia have been encouraged and supported to lead on the publication of this paper; imbalances in publication pace among local teams is skewed to those with the resources already in place, so to address this imbalance, we developed a publication agreement that papers that address global issues should integrate members from traditionally excluded contexts and identities in leadership

GMH=global mental health. HEROES=COVID-19 HEalth caRe wOrkErS study. HICs=high-income countries. LMICs=low-income and middle-income countries.

Table: **Concepts and practice examples**

silencing from meaning-making activities, misrepresentation of one's contributions, or having a diminished status in communicative practices.[23] Such unfair practices lead to an extermination of diverse types of knowledge and ways of knowing, which allows colonial structures of knowledge to dominate.[7,24] For instance, it is still common that the so-called local investigators have limited involvement in designing studies, analysing data, and

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writing research manuscripts. Their selection as local investigators in these instances often has more to do with logistical or bureaucratic reasons rather than the acceptance of their worthiness as knowledge holders and contributors. In other words, most academic production in global mental health is still controlled by research teams and institutions from the USA and Europe. Although those teams tend to be sensitive and aware of the aforementioned power asymmetries, too few global mental health projects are actively engaging individuals in the co-creation of structures and mechanisms that would allow for a fair and inclusive epistemic production process.[25]

To address this issue, HEROES was co-created to engage and involve stakeholders equally in all research procedures from its inception. We sought to avoid the colonial global mental health approach of imposing pre-determined topics of interest or methodological approaches and to foster a more horizontal working relationship and decision making. For example, unlike traditional multicentered studies, HEROES does not have a pre-defined, unique, and unmodifiable survey, although there are core components that will allow comparability across countries. Owing to our team's approach, the decision to put our diversity (ie, languages and dialects) at the forefront of the project was unanimous. For example, research materials (eg, study protocol, measures, and web-based survey) were developed, translated, and adapted almost simultaneously in all the participating countries and in close partnership between all team members. Although the administrative and IT teams supported the coordination of this process through weekly bilingual meetings and infrastructure, the local principal investigators and team members in each country decided what was feasible and meaningful to do, depending on their own local contexts. This approach has allowed us to frame our methods from an epistemic justice perspective to reflect and respond to the ever changing specific needs of the countries and their sociopolitical contexts. Several collaborators have had to deal with challenges along the way, such as civil wars (eg, Armenia), major financial meltdown and the strongest ever recorded non-nuclear explosion (eg, Lebanon), political corruption (eg, Bolivia), gender-based violence (eg, Guatemala), and natural disasters (eg, Puerto Rico). Having horizontal working relationships has allowed us, as a team, to actively resist hegemonic methodological research practices and do our best to diligently provide accompaniment to our collaborators as needed. For example, by mutually agreeing for additional time to start studies or integrating additional instruments to assess the impacts of these local crises.

Pragmatic solidarity

Pragmatic solidarity is a tangible and material form of solidarity that aims to diminish unjust hardship[26] and emphasise the need to move beyond a charity-like solidarity by giving power and concrete resources to those in need. From our perspective, another less evident issue that is key for a decolonial approach is the recognition that power and privilege are embedded in all global mental health research endeavours and that we must engage in deliberate actions to dismantle them from within teams. Although the concept of pragmatic solidarity has traditionally been applied to global health more broadly, here we apply it to address the unjust hardships that global mental health researchers in or from LMICs experience. Some well known difficulties for engaging in global mental health research efforts include a paucity of research infrastructure and resources, extensive local expertise but misalignment with US or European research priorities, language barriers, and insufficient financial support.

We have addressed some of these difficulties by identifying and sharing local and global resources and infrastructure to support collaborators worldwide. One specific example from HEROES is that the data for all countries are held in a data centre that is physically located in Santiago, which has been applauded by all the teams and acknowledged as one of the assets of our study. All our collaborators can use this free-of-charge platform, which is designed, daily managed, and cleaned in its entirety by the IT team at the University of Chile (Santiago, Chile) to meet international standards for data management. Most team members have used the platform but others have opted not to do so. This location means that people based in the USA and Europe had to let go of their traditional power and people from other contexts (in this case Chile, a South American country) had to actively claim agency and leadership in global mental health research collaborations.

In our case, a particular challenge has been that HEROES as a whole is not currently funded; this has been particularly challenging as support for local teams is poor. Despite this limitation, the administrative and IT teams have supported some research teams at the country level who have had access to mostly local (eg, Spain and Mexico) funds via successful small grant applications. However, although this access has allowed flexibility, openness, and solidarity, it is highly challenging to sustain such a large study without funding, which is a difficult problem that needs to be acknowledged and addressed when transforming the field. Additionally, not all countries have benefitted from this support, which shows some of the imbalances that often can arise and challenges our efforts to fully engage in a pragmatic solidarity practice.

Another example of a resistance practice is what we call *acompañamiento* (Spanish for accompaniment). Members of our team, especially junior investigators from or in LMICs, have been supported by other junior and senior researchers from both HICs and LMICs. This is not a minor issue, particularly for those who, because of coloniality (and simultaneous colonialism, a

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political system of control by one country over another, as is the case for authors from Puerto Rico)[27] sometimes believe they have nothing to say about, or add to, global mental health research collaborations. Thus, creating the spaces for open and participatory dialogue falls short as a decolonial practice if these are not used by those who are not seen or whose voices are not heard. As Abimbola and colleagues[22] put it, "claiming space requires confidence. It requires that we believe that 'we can'…often, we just assume we are not good enough or trained enough." Having peers to rely on has been a fundamental decolonial practice that has benefitted the team as a whole (ie, fostering active engagement among members and avoiding tokenism) and individual members (eg, one of the first authors) to decolonise their minds[22,28] by claiming their agency and responsibility (ie, this article).[9]

Sovereign acts

Sovereign acts are the capacity to reimagine oneself and act outside the imposed norms, especially norms from established authorities, leading to other ways of being in the world.[29] Thus, it is the capacity to act and be engaged with the world in alternate ways that enables people to create spaces where they can feel safe, cared for, and worthy.[30] From our perspective, self-governance can allow research teams to contest the hegemonic practices in global mental health that perpetuate power imbalances in the field. One example is global institutions, usually based in the USA or Europe, owning and publishing data that are collected elsewhere, in what is now known as extractive practices. Although this approach has been widely criticised, researchers still sometimes need to pay a fee to get access to global data to which they have contributed and have to sign unfair data agreements to participate in global initiatives. To maximise sovereignty, each country involved in HEROES owns its data and has the right to decide what to do with them. This ownership means that individual country teams decide whether they want to participate in cross-cultural analyses and publications. Additionally, it is up to each team to prioritise how to best use their data. For example, although not mutually exclusive, some teams have prioritised to move forward with traditional data dissemination via peer-reviewed journals and others have decided to disseminate the data among their stakeholders or go on to address the key identified issues. The prioritised strategies for dissemination and research topics always emerge from each individual country team and are never imposed from the administrative team or any other team, although there are some shared priorities.

Final thoughts

In this Personal View, we shared our HEROES team-building approach to challenging the coloniality of global mental health collaborative research initiatives. Since about 2012, the recognition of the coloniality of global mental health and the need to decolonise the field have gained momentum.[14,15] This recognition has led to an important discussion that aims to address the power asymmetries and colonial practices that hinder the field's transformation.[12] However, this discussion has been largely driven by the USA and Europe and characterised by an absence of pragmatic approaches, which has led some researchers to question individual and institutional motivations and commitment to the decolonial rhetoric on system transformation.[18,21] Despite this situation, there is some evidence that suggests that specific decolonial practices are growing. Examples include the implementation of dialogical reflexivity (the continuous process of selfpositioning and understanding and dialogue with peers to move from insight to action)[21] or the application of broader strategies, such as the pragmatic or so-called common sense approach,[19] to challenge organisational and institutional manifestations of coloniality. These approaches share the understanding that, to address the coloniality of global mental health and for equitable research collaborations to occur, institutions and individuals with power need to find ways to relinquish, and ultimately give up, their power.[22] Conversely, those marginalised and excluded need to claim their space and their agency.[9] Thus, if the goal of global mental health is to achieve equity in health, both within and between nations,[1] then actively resisting hegemonic methodological practices and approaches that do not align with this aim will benefit researchers and stakeholders within teams and will push global mental health closer towards this goal. A decolonial approach to global mental health benefits people and institutions whose mission is global health and benefits the whole world in terms of health. However, it might not be immediately perceived as a benefit by institutions and individuals in power. Although still evolving through our reflective practices, we believe our HEROES decolonial approach benefitted the team as a whole by addressing some of the global mental health power imbalances at the team building level as an important ongoing means to achieve the ultimate goal of dismantling the coloniality of global mental health.

Conclusion

In this Personal View, we presented our decolonial global mental health research collaboration based on our HEROES study as an example to address and move beyond the discussions of coloniality. Our proposed three-principle decolonial approach aims to provide a space to enact resistance practices at the team building and knowledge production levels to challenge the coloniality of global mental health. The principles are not fixed or universal, nor do they intend to be. However, sharing our approach and specific practices aims to continue the conversation and, perhaps more importantly, encourage others to articulate their own ways of doing decolonial global mental health research.

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We believe that to address the coloniality of global mental health successfully, team-building approaches, such as HEROES, that consciously engage in counterhegemonic actions are essential.

Contributors
ER-S and FM contributed to the conceptualisation, writing of the original draft, and review and editing. Both authors contributed equally. All other authors wrote the Personal View and contributed to editing.

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