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From Preproduction to Coproduction: COVID-19, whiteness, and making black mental health matter

Medical training that dismisses the importance of cultural values, assumes scientific objectivity, and practises coded racialised diagnostic values, shows no accountability to the lived experience of Black people, including the many who have died during the COVID-19 pandemic.¹ Current medical practise might be seen as a colonial biomedical knee analogous to that which killed George Floyd, because it fails to see how it denies the life of Black people. Unfortunately, as Gillard and King² suggest, we remain in tribal zones and cultural camps that rarely share the power of racialised realities to address cultural myths promoted by Whiteness inside psychiatry, and hence help the profession to liberate itself from its colonial past. The crucial challenge is the achievement of political equity in the transition from the preproduction stage of disempowerment and slavery to the empowerment of Black communities in the coproduction stage involving meaningful collaboration with the medical profession. It is thus crucial to examine the specific effect of current medical training concerning Black people's experiences of both mental health and COVID-19.

This challenge of equity between White psychiatry and the Black community is rarely articulated, and hence the possibility to change medical training within psychiatry is unrealised. True equity demands movement from a focus on symptoms in the individual to understanding and interpreting the effects of broader structural factors of race inequality. The transition from preproduction to coproduction has rarely been considered, and is challenging, as it will involve genuine equality of power across the colour line. Coproduction requires adoption of a joint conception of race and mental health, and a strategy that engages with the Afro-centric contribution to a social justice approach to our current diagnostic frameworks in the era of COVID-19, as outlined in the work of Amos N Wilson.³

The vision is thus not merely to decolonialise prevailing Eurocentric theories within both psychiatry and clinical psychology training, but to develop transcultural, anti-racist, and inclusive models, that will politicise the lived experiences of the Black community as relevant to future practises of psychiatry.

The objective is a coproduction that works effectively across the colour line by working beneath what Frantz Fanon⁴ terms the "racialised mask" that covers true identities, and by breaking through, in the words of W E B Du Bois⁵, our "cultural veil" of our conscious self definition. Consequently, new collaborative models are needed that will support a redistribution of power so that we can redress urgent issues such as the illegal imprisonment of Black communities inside the mental health care system. This redistribution of power will involve a radical political approach to our racialised masks. Reformation of White westernised medical science must move beyond merely a decolonisation of its past, to a new empathetic practise that redistributes conceptual and diagnostic powers to the Black voice in medical science, mental health work, and in the context of COVID-19.

Bringing the lived expertise and validation of Black survivors' voices into psychiatric training is the essential basis of authentic change. Current practise involves the denial of processes of discrimination and cultural entrapment that are derived from the values of psychiatry's White colonial past. Moving away from the limitations of White psychiatry will require a reappraisal of the values of Whiteness.⁶ Lived first-person experience⁷ should support a coproductive approach based on accepting changes to both historical and current models of mental health. Without such changes, the increase in the number of Black psychiatrists, or superficial changes to the models of mental health, will not lead to new and necessary changes to medical values and practise. The Black Lives Matter slogan is just a starting point for a more fundamental challenge to the processes, power, and values that maintain systematic racism.

COVID-19 has increased the risk of the erosion of Black communities. The vulnerability of Black communities to COVID-19 is in part because medical science, dominated by White disillusion of its impartial practise, has failed to appreciate the systemic racism that leads to race inequalities. Current medical practise risks repeating in modern form the concept of drapetomania, a so-called mental illness that caused slaves to escape their captivity, proposed by the nineteenth-century American

physician, Samuel Cartwright.⁸ Cartwright's prejudice and incomprehension of the Black lived experience are echoed in today's cultural and racial medical practise, and the challenges Black academics face in unchanging White models of psychiatry. Dismantling the current colonised practises of education and training in psychiatry is not enough.⁹ Beyond Black faces and new models, there is a need to embrace an Afro-centric approach to current psychiatric diagnosis to safeguard against the unlawful and unethical detention of Black people in the mental health system.

The call for authentic changes to ensure Black lives matter will require working across the colour line. This means adopting processes in which the lived experiences of Black men and women are at the centre of psychiatric training, psychiatric models, and psychiatric theories and practises. But it also means adopting a coproduction model informed by both cultural and political accountability. It is this coproduction model that has been the central ethos of the Race Equality and Whiteness Network of which we the authors are all members. This model is at the heart of the personal and professional considerations required of psychiatrists and psychologists if they are to move from taking the knee to standing up for genuine change. We need to move on from the current preproduction stage that examines the privileges of Whiteness, through a process of

coproduction that relinquishes its powers, and thus to a truly postproduction future of equity in mental health work across the colour line.

We declare no competing interests

*Colin King, Michael Bennett, Kenneth W M Fulford, Simon Clarke, Steve Gillard, Anna Bergqvist, John Richardson
cbking@hotmail.co.uk

Department of Philosophy, University of Oxford, Oxford OX1 2JD, UK (CK, KWMF, SC, JR); Professional Footballers Association, London, UK (MB); Department of Mental Health, City University of London, London, UK (SG); Department of Philosophy, Manchester Metropolitan University, Manchester, UK (AB).

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