Mastering JEDI Skills for Current Times

2020 and 2021 have brought many images of social and medical equity to the forefront, including what some call a syndemic. This term speaks to the interaction of health (COVID-19) and social problems (systemic racism).[1,2] Others also identify economic issues as part of the syndemic. In the United States, I believe that this includes not only the health disparities related to those who have died disproportionately, but also racially based violence, including violence against those who are of East Asian descent.[3,4,5]

This issue of *JAACAP Connect* is designed to familiarize the reader with important justice, equity, diversity, and inclusion (JEDI) concepts that are relevant to the practice of child and adolescent psychiatry. A complete understanding of social and cultural aspects of psychiatry requires a grounding in concepts describing cultural identity as well as the existence and influences of structural racism. One example of how these factors have become more visible in our professional lives over the past year is the impact of access to broadband internet on telepsychiatry (our new primary mode of care) and virtual learning for many of our patients.

We thank the UCLA Department of Psychiatry for the use of the term JEDI to describe an "antiracist, social justice, structural competency framework" that encompasses the ideals we are discussing in this issue of *JAACAP Connect*.[6] We thank George Lucas, creator of the *Star Wars* Universe, for bringing the term Jedi into the world-wide lexicon, referring to the knights that served as guardians of peace and justice a long time ago in a galaxy far, far away.

"Social Determinants of Health, Structural Racism, and the Impact on Child and Adolescent Mental Health" is an excellent lead article for our issue, setting the stage with a firm grounding in this fundamental concept. Social determinants of health are the conditions in which people are born, grow, work, live, and develop;[7] these non-medical factors have a significant influence on health and mental health outcomes. Drs. Cotton and Shim provide a clear description of social determinants and the required cognitive shifts needed for mental health professionals to incorporate this understanding into our care of patients and families.

Social determinants include the impact of the systems in which any or all our patients are involved: community supports, housing quality, educational system, social services, health care, disability services, employment opportunities, juvenile justice systems, and how the society's values and community dynamics interface with the child's identities.[8] Drs. Campbell, McClendon, Salem, and McBride introduce us to the disparities in our legal and juvenile justice systems, beginning a series of articles with a spotlight on juvenile justice. This is relevant not only for forensic and correctional psychiatrists, but for all of us, as the themes addressed often directly relate to what is happening within educational systems and other systems that are relevant to most of our patients.

The JEDI issue is written by a diverse set of authors who are often transparent in bringing their own social and cultural experiences into their contributions. We believe that all clinicians should begin to incorporate the impact of the patient's cultural identity in their perceptions, clinical presentation, interactions, and our diagnosis and treatment. As an African American woman I recognize, as we read the articles in this issue, that there are *multiple* subsets of individuals who identify themselves as Brown, Black, and Asian. This may be confusing for some who are just beginning to approach these issues, but recognizing the cultural identity is the core of what we need to understand—how every individual identifies themselves, and what that means for how they interact with the world.

Dr. Shadid's "Race Against the Mental Status Exam," brings us into the middle of a debate. It is critical to state clearly that we recognize that there is diversity in opinion

and thought regarding this discussion. Cultural identity is determined by the individual, not the clinician. The debate is regarding whether race should be mentioned in the description of a patient, particularly without asking the question of the patient. There are some who believe that the race should not be mentioned in our clinical histories, as *race is not a biological factor*. However, it is *undeniably* a sociocultural factor that can become a determinant of health[9] that impacts mental health and other health disparities, and, given its importance in day-to-day life in the US, seems important for mental health providers from a conceptualization/formulation perspective for that reason alone. In "Building Up and Breaking Down: Youth Cultural Identity Development" by Drs. Arshad, Chua, and Baker, we begin to learn about cultural identity and its development in all individuals. We also begin to learn about intersectionality.

"Implicit Bias in Psychiatry: It's Time for More Than Uncomfortable Conversations Among Physicians," by Drs. Rogers, Wadhwa, and Green describes disparities in psychiatry and the protective nature of a strong racial/ethnic identity. They share that the Project Implicit site (**https://implicit.harvard.edu/implicit/index.jsp**) is useful for those with interest in self-exploration related to bias. With this tool, you can assess your potential for bias related to age, disability, ethnicity, gender, gender identity, race, or sexual orientation as well as other descriptors.

Intersectionality is further addressed in "Supporting LGBTQ2S Youth Who Are Black, Indigenous, and People of Color (BIPOC)." This article by MD candidates Thelwell, Chiwiwi, and Kantor begins by guiding the reader through language, starting with use of the most affirming terms: lesbian, gay, bisexual, transgender, queer, and Two-Spirit, thus providing inclusion, not merely tolerance, for these youth of color for whom we provide care. We then learn more about how we can help our patients and families identify supports with evidence supporting their use. This includes an understanding of two terms. The first is *decolonization*, "the active resistance against colonial powers and a shifting of power towards political, economic, educational, cultural, psychic independence and power *that originate from a colonized nation's own indigenous culture*" (emphasis added) which occurs on personal, societal and political levels.[10] The second term is *decolonial*. This approaches the same concepts from the perspective of those who settled on the land that was colonialized: "Decolonial approaches, methods, and movements seek to disrupt colonial and settler-colonial logic and the seeming "naturalness."[11] The appreciation of these terms is closely related to recognizing the existence of structural racism.

Racism is another determinant of health.[9] "Antiracism Work in Schools: Using Dialectical Behavioral Therapy Skills to Empower South Texas Educators" by authors Yang, Crous, Balli-Borrero, Choi, and Robles-Ramamurthy reports a project designed to help us address this barrier in our work with school consultation and with educators. Finally, various contributors discuss a list of resources for *Connect* Corner to further help you in your journey to become adept in the JEDI arts of providing care for children, adolescents, and families.

Utilizing the resources in this issue of *JAACAP Connect*, we all have additional knowledge to help us be able to develop our personal skills and move forward with a commitment to become a JEDI Master in seeking *Justice* for all, recognizing the need for mental health *Equity*, valuing the *Diversity* of individuals and thought, and discerning when *Inclusion* is not truly present. I hope you enjoy reading this issue as much as I did editing it.

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Guest Editor

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