ACLP MEMBERSHIP SURVEY REGARDING DIVERSITY, EQUITY, INCLUSION, AND ACCESSIBILITY

INTRODUCTION

The Academy of Consultation-Liaison Psychiatry (ACLP) established the Diversity, Equity, Inclusion, and Accessibility (DEIA) Subcommittee within the Membership Committee. Based on the report of the ACLP Presidential Task Force on DEI released in 2021, the Subcommittee recommended a survey of members regarding diversity and related issues. An outside company was engaged, but their proposed survey was more oriented towards a corporate context and did not meet our needs. The Subcommittee and the Board of Directors prepared a survey more reflective of the ACLP's context. The survey inquired about the composition of our membership and their attitudes towards progress in DEIA areas, and solicited open-ended responses to four queries.

METHODS

The survey was conducted with online software, with multiple requests for participation sent by e-mail to members of the ACLP (2,324 individuals). Responses were collected from October 1 to November 20, 2024. The initial questions concerned membership type, professional role, and demographics. These were followed by 20 attitude questions in 4 domains: Welcome (4 items whether the ACLP was welcoming to 4 subgroups), Equitability (4 items whether the ACLP was equitable in treatment of these 4 subgroups), Coverage (5 items whether the ACLP well covered issues related to 5 subgroups), and Organization (7 items related to the respondent's relationship to the organization). Finally, 4 open-ended items were included, concerning how the ACLP has lived up to its DEI goals, how the ACLP could improve, how the ACLP could better meet member educational needs, and any other comments (see Supplemental Table S1 for full details). A total of 468 respondents continued beyond the member type question, but 52 indicated they were not ACLP members, so 416 member responses were available for analysis (a response rate of 17.9%). Comparisons between categorical outcomes were made with chi-square or exact tests as appropriate. Attitude responses were coded as integers, with 1 being "Strongly disagree," 2, "Disagree," 3, "Neutral," 4, "Agree,", and 5, "Strongly agree," and analyzed as numerical measures. The mean of available scores for the Welcome, Equitability, Coverage, and Organization items, as well as the overall mean of these 4 means, was calculated by respondent. Cohen's *d* was calculated as a measure of effect size. The percentage of respondents answering "Agree" or "Strongly agree" was also calculated as an alternative analysis. Open-ended responses were classified by theme: if an individual response referred to more than one theme, each theme was separately counted. Statistical analysis was conducted using SPSS Statistics (version 29.0.1.0, IBM, Somers, NY).

RESULTS

Demographic analysis

Member respondents comprised 344 full members (82.7%), 51 trainee members (12.3%), and 21 associate members (5.0%; see Table 1). Most members were board-certified in Consultation-Liaison (CL) Psychiatry (73.5% of full members). Trainee members included residents in psychiatry and fellows in CL Psychiatry,

comprising 51.0% and 43.1%, respectively. Advanced Practice Nurses (NPs) and Physician Assistants (PAs) comprised 38.1 % and 28.6% of the associate member respondents.

Demographic factors are reported in Table 2. Full members were evenly divided between respondents identifying as Man and Woman, with 50.6% identifying as Woman, while trainee members and associate members were more likely to identify as Woman, comprising 60.8% and 70.0%, respectively (Non-binary, Trans, and Other categories were small in proportion). Time since training spanned a broad range among full member and associate member respondents. Most members completed medical training in the US (78.7%, 89.6%, and 57.1% among full, trainee, and associate members). The fraction of full members reporting a health impairment was 6.3%, which included impairments in hearing (3.2%), vision (0.6%), mobility (1.3%), and other medical-neuropsychiatric conditions (1.8%). The most common work setting was the academic inpatient hospital for full and trainee members, 52.0% and 65.3%, respectively, but the community inpatient hospital for associate members, 50.0%. The fraction of full members reporting Lesbian, Gay, Bisexual, Trans, Queer or Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2S+) identity was 15.1%, while trainee members reported a significantly larger fraction at 34.0%, and associate members reported 5.3%.

The most common work region was the Northeast US for full members and trainee members, 37.7% and 42.9%, respectively and the South US for associate members, 38.9% (Table 3). The most common racial/ethnic category was White, indicated by 62.2%, 62.7%, and 77.8% of full, trainee, and associate members, and the next most common was Hispanic/Latino, 15.7%, 11.8%, and 11.1%, respectively. For trainee members compared to full members, there was a greater number with Black/African American (11.8 vs 6.4%) and East Asian (13.7 vs 4.5%, $p<0.05$) ethnicity.

Attitude score analysis

The pattern of mean agreement scores across the 20 attitude items is shown in Figure 1 (all member respondents, black line). There was general agreement with the Welcome and Equitability items, but lower agreement with the Coverage items. The lowest scores pertained to the Disability item within each of these three domains. Among the Organization items, respondents indicated lowest agreement with regard to the leadership diversity item (individual item scores are shown in Supplemental Table S2; Supplemental Tables also show analysis by percentage agreement, which demonstrates similar patterns of response).

Several underrepresented subgroups had lower mean agreement scores across the full range of items. Respondents identifying as Woman had lower agreement scores on all items compared to respondents identifying as Man (Figure 1, Supplemental Table S2). Respondents identifying as LGBTQIA2S+ had lower agreement scores on all items compared to individuals not so identifying (Figure 2, Supplemental Table S3). Scores for the largest race/ethnic groups (White, Hispanic, East Asian, South Asian, and Black/African American) are shown in Figure 3. All four non-White groups showed generally lower agreement scores, compared to White respondents (Supplemental Table S4).

Overall mean agreement scores are shown in Table 4, as well as summary mean agreement scores for the Welcome, Equitability, Coverage, and Organization domains. Individuals identifying as Woman, LGBTQIA2S+, South Asian, Black/African American, and East Asian respondents have significantly lower Overall mean agreement scores. This table also includes data for members, trainee members, and associate members: trainee and associate members did not have significantly different Overall agreement

scores compared to full members. There were no statistically significant differences by region (data not shown).

Open-ended response analysis

Respondents were invited to make 4 open-ended entries (Supplemental Table S1). Entries were coded by themes expressed and summarized in Table 5 (if a response expressed more than one theme, each theme was separately counted). Regarding query #1 (Progress), which inquired about progress made by the ACLP to date in the DEIA area, 104 positive comments were offered: within these responses, issues noted included coverage of DEIA topics (38 mentions), the DEIA Subcommittee/Task Force (15 mentions), and diversity of Special Interest Groups (SIGs) (11 mentions). Nine respondents called for increased efforts regarding DEIA, and 6 respondents opposed increased efforts. There were also comments that the annual meeting may not be welcoming toward people with a diverse political perspectives.

Regarding query #2 (Needs), which inquired about further needed improvements in the area of DEIA, 36 comments called for increased efforts: suggestions for improvement included comments about increased coverage of DEIA topics (16 mentions), increased minority outreach (10 mentions), and promoting more membership diversity (4 mentions). Eleven respondents opposed increased efforts. There were also 23 critical comments concerning Annual Meeting location and 22 critical comments concerning a lack of transparency and diversity in ACLP leadership selection.

Regarding query #3 (Education), which inquired about ACLP educational endeavors, 48 mentions supported improved DEIA coverage, and 13 opposed. Regarding query #4 (General), which solicited any other general comments, more comments favored increased DEIA efforts than opposed, 22 versus 13. For typical comments from the largest thematic areas, see Supplemental Table S5.

The following themes received two mentions: urging improved mentorship; questioning LGBTQIA2S+ acceptance at ACLP; urging more attention in SIGs to new members; urging a wider concept of White/Caucasian; and awaiting further research before advocacy for Trans issues. The following themes received one mention: urging increased attention to non-academic settings; supporting the virtual option for the Annual Meeting; urging childcare at meetings; urging support for declined submissions; urging more on alternate career paths; urging more opportunities for Mexican CL psychiatry involvement; urging attention to areas without CL psychiatry programs; emphasizing attention to inclusion as well as diversity; advocating for international medical graduates in psychiatry and CL psychiatry; urging more attention to working class and Latino populations; urging more sessions at meetings; urging increased attention to religion; urging more talks about sexuality; noting antisemitism in ACLP; urging more attention to non-CL psychiatrists; noting disproportionate participation from East Coast institutions; urging improving annual meeting for those with health issues; urging increased attention to rural practitioners; urging broader focus of DEIA besides gender identity/sexuality issues; reporting limited awareness regarding ACLP support for DEIA in ACLP; urging attention to communication across generational groups; urging advocacy for higher salaries for CL psychiatry; and reporting too many ACLP emails.

CONCLUSIONS AND LIMITATIONS

The survey offers an image of full members that is within expectations. The largest group of respondents were full members (83%), who were approximately equally divided between identifying as Man or Woman

(51% Woman). The largest region represented was the Northeast US (38%). About half worked chiefly in inpatient academic hospitals (52%), and most were board-recognized in CL Psychiatry (73%). Of full member respondents, 15% identified as LGBTQIA2S+. The largest racial/ethnic group was White (62%), followed by Hispanic/Latino (16%), South Asian (7%), Black (6%), and East Asian (4%). By contrast, while the percentage of Hispanic/Latino and Black/African American groups in the U.S. population census[1] are 19% and 14%, the percentages in psychiatry residency training[2] are 11% and 8%, and the percentages among US physicians[3] are 6% and 5%.

The analysis of trainee and associate members points to a changing composition of the organization. Trainee members, chiefly psychiatry residents and CLP fellows, represented 12% of respondents and differed in having a significantly increased proportion of LGBTQIA2S+ (34%) and East Asian (14%) identities, with a trend towards increased Black (12%) identity, showing a small increase in diversity. Associate members comprised 5% of respondents, chiefly NPs and PAs, and appeared to have a larger representation in community inpatient hospitals (50%) and in the South (39%) and Midwest US (22%).

Most respondents rated the ACLP favorably over the 20 attitude items. With "3" indicating neutral views, "4" indicating agreement, and "5" indicating strong agreement, the Overall mean response was 3.91 ± 0.81, suggesting agreement but not strong agreement for most items. Mean scores were lower for the disability item within each of the Welcome, Equitability, and Coverage domains, compared to other subgroups. Among the Organizational attitude items, the lowest mean scores concerned the diversity of ACLP leadership.

However, individuals from multiple subgroups perceived the ACLP in a less favorable fashion. Individuals identifying as Woman, LGBTQIA2S+, South Asian, Black/African American, and East Asian respondents gave less favorable ratings across the entire range of attitude items: individuals belonging to specific subgroups tended to give lower ratings on all items, not only on items related to their own identity.

Open-ended responses reflected a similar range of viewpoints, with more respondents favoring increased attention to DEI issues. Issues regarding the Annual Meeting location and the diversity of Academy leadership attracted the most comments. Increased attention to disabled and neurodivergent populations and improved inclusion of advanced practice providers attracted the next most frequent comments.

Additional suggestions about the Annual Meeting supported virtual options, increased session number, childcare, support for declined submissions, aid for attendees with health issues and for international attendees, including those from Latin America.

Finally, a small number of individual comments called for increased attention to some non-traditional CL areas, including non-academic settings, alternate career paths, areas without CL psychiatry programs, non-CL psychiatrists, rural practitioners, international medical graduates, working class and Latino populations, religion, and sexuality.

Limitations of the study included a sample size of 416, which represents a response rate of 18% from member emails sent. The results presented might not be typical of the whole membership, and individuals

with particular viewpoints may have been more or less likely to participate. Additionally, the sample size limited the ability to study smaller subgroups of members.

The results have important implications for action. First, the organization as shown in this sample appears far from the diversity of the US population, and increased efforts are needed to broaden the representation of diverse subgroups within the ACLP. Second, a clear priority is attracting the participation, and promotion into leadership, of all members. Third, lower ratings were related to inclusion and coverage of subgroups with disabilities. Fourth, while the survey shows a generally positive view of the management of DEIA concerns by the ACLP, that perception is lower among women, LGBTQIA2S+, and South Asian, East Asian, and African American subgroups. The ACLP must enhance outreach to ensure all subgroups feel welcome in the organization. Fifth, open-ended comments show overall agreement with past and current efforts in the DEIA domain, but Annual Meeting location, leadership diversity, issues related to disability and neurodivergence, and inclusion of NPs and PAs attracted the most concern. Lastly, comments about improving annual meeting accessibility and increasing inclusiveness of non-traditional areas of CL Psychiatry should influence future policy.

ACKNOWLEDGEMENT
We are delighted to thank Ralitza Gueorguieva, PhD, for the review of the statistical analysis of the survey data.

NOTES
[1] United States Census Bureau. Population Estimates, 2024. https://www.census.gov/quickfacts/fact/table/US/PST045221 (Accessed March 11, 2024)
[2] Accreditation Council for Graduate Medical Education, Department of Information Services. *Data Resource Book, Academic Year 2023-2024*
[3] American Association of Medical Colleges. U.S. Physician Workforce Data Dashboard, 2024 Key Findings. https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions

TABLE 1: Respondents by member type

	N (% total sample)
Full member	**344 (82.7%)**
Psychiatrist, board-certified in CL Psychiatry	253 (60.8%)
Psychiatrist, not board-certified in CL Psychiatry	90 (21.6%)
Physician, not a psychiatrist	1 (0.2%)
Trainee member	**51 (12.3%)**
Resident (psychiatry)	26 (6.3%)
Fellow (CL psychiatry)	22 (5.3%)
Medical student	2 (0.5%)
Other trainee	1 (0.2%)
Associate member	**21 (5.0%)**
Advanced Practice Nurse (NP, APRN)	8 (1.9%)
Physician assistant	6 (1.4%)
Nurse	2 (0.5%)
Other Associate Member	2 (0.5%)
Social Worker	2 (0.5%)
Psychologist	1 (0.2%)
TOTAL	**416 (100.0%)**

A total of 416 respondents indicated that they were members of the ACLP: subgroups of professional role are shown.

Table 2: Respondents by demographic factor

		Full member	Trainee member	Associate member
Identification	Man	156 (48.1%)	19 (37.3%)	6 (30.0%)
	Woman	164 (50.6%)	31 (60.8%)	14 (70.0%)
	Non-binary, Trans, or Other	4 (1.2%)	1 (2%)	0 (0%)
Time since training	Currently in training	2 (0.6%)	49 (96.1%)	0 (0%)
	7 years or less	111 (32.3%)	2 (3.9%)	8 (38.1%)
	8 to 10 years	42 (12.2%)	0 (0%)	4 (19%)
	11 to 15 years	54 (15.7%)	0 (0%)	1 (4.8%)
	16 to 20 years	35 (10.2%)	0 (0%)	3 (14.3%)
	21 years or more	100 (29.1%)	0 (0%)	5 (23.8%)
Medical training	US	247 (78.7%)	43 (89.6%)	8 (57.1%)
	non-US	67 (21.3%)	5 (10.4%)	6 (42.9%)
Impairment	No	296 (93.7%)	46 (97.9%)	21 (100%)
	Yes	20 (6.3%)	1 (2.1%)	0 (0%)
	Hearing	10 (3.2%)	0 (0%)	0 (0%)
	Vision	2 (0.6%)	0 (0%)	0 (0%)
	Mobility	4 (1.3%)	0 (0%)	0 (0%)
	Other	6 (1.8%)	1 (0.3%)	0 (0%)
Workplace	Inpt hosp, academic	171 (52.0%)	32 (65.3%)	3 (16.7%)
	Inpt hosp, community	24 (7.3%)	3 (6.1%)	9 (50.0%)
	Inpt hosp, government	18 (5.5%)	2 (4.1%)	1 (5.6%)
	Outpt clinic, academic	51 (15.5%)	9 (18.4%)	1 (5.6%)
	Outpt clinic, community	17 (5.2%)	0 (0%)	2 (11.1%)
	Outpt clinic, government	5 (1.5%)	0 (0%)	0 (0%)
	Private practice	19 (5.8%)	0 (0%)	0 (0%)
	Other	24 (7.3%)	3 (6.1%)	2 (11.1%)
LGBTQIA2S+	No	269 (84.9%)	33 (66.0%)	18 (94.7%)
	Yes	48 (15.1%)	17 (34.0%)*	1 (5.3%)

*Demographic information is compared among full members, associate members, and trainee members. Respondents who indicated they preferred not to answer or left items blank were not included in tabulations related to those items. Statistical comparisons with chi-square or exact tests were performed between full member and associate or trainee member for dichotomous outcomes (identifying as Woman vs Man and LGBTQIA2S+ vs non-LGBTQIA2S+), with significance at p≤0.05 shown by *.*

TABLE 3: Respondents by region and racial/ethnic group

		Full member	Trainee member	Associate member
Region	US, Northeast	124 (37.7%)	21 (42.9%)	1 (5.6%)
	US, South	61 (18.5%)	7 (14.3%)	7 (38.9%)
	US, Midwest	53 (16.1%)	13 (26.5%)	4 (22.2%)
	US, West	50 (15.2%)	7 (14.3%)	3 (16.7%)
	US, Northwest	12 (3.6%)	1 (2%)	0 (0%)
	US, other	1 (0.3%)	0 (0%)	0 (0%)
	Alaska	0 (0%)	0 (0%)	1 (5.6%)
	Hawaii	3 (0.9%)	0 (0%)	0 (0%)
	Puerto Rico	4 (1.2%)	0 (0%)	0 (0%)
	Asia	0 (0%)	0 (0%)	1 (5.6%)
	Australia/New Zealand	1 (0.3%)	0 (0%)	0 (0%)
	Canada	7 (2.1%)	0 (0%)	0 (0%)
	Europe	4 (1.2%)	0 (0%)	1 (5.6%)
	Mexico	3 (0.9%)	0 (0%)	0 (0%)
	Middle East	1 (0.3%)	0 (0%)	0 (0%)
	South/Central America	3 (0.9%)	0 (0%)	0 (0%)
	Other (please specify)	2 (0.6%)	0 (0%)	0 (0%)
Race/ethnicity	White	194 (62.2%)	32 (62.7%)	14 (77.8%)
	Hispanic/Latino	49 (15.7%)	6 (11.8%)	2 (11.1%)
	South Asian	23 (7.4%)	3 (5.9%)	0 (0%)
	Black/African American	20 (6.4%)	6 (11.8%)	1 (5.6%)
	Race: other	17 (5.4%)	3 (5.8%)	1 (5.5%)
	East Asian	14 (4.5%)	7 (13.7%)*	1 (5.6%)
	Southeast Asian	13 (4.2%)	4 (7.8%)	0 (0%)
	Mid Eastern/Nor African	10 (3.2%)	2 (3.9%)	0 (0%)
	Am Indian/Alaska Nat	3 (1.0%)	0 (0%)	0 (0%)
	Any non-White	129 (41.3%)	28 (54.9%)	4 (22.2%)

*Region and race/ethnicity information is compared among full members, associate members, and trainee members. Respondents who indicated they preferred not to answer or left items blank were not included in tabulations related to those items. Statistical comparisons with chi-square or exact tests were performed between full member and associate or trainee member for each individual race/ethnic subgroup, with significance at p≤0.05 shown by *.*

TABLE 4: Mean Welcome, Equitability, Coverage, and Organization agreement scores

	Welcome (mean)	Equitability (mean)	Coverage (mean)	Organization (mean)	Overall (mean)
All members	4.10 ± 0.92 (394)	4.00 ± 0.97 (394)	3.65 ± 0.91 (323)	3.81 ± 0.89 (330)	3.91 ± 0.81 (395)
Man	4.18 ± 0.94 (177)	4.12 ± 0.98 (177)	3.73 ± 0.89 (149)	3.94 ± 0.83 (152)	4.01 ± 0.75 (177)
Woman	4.03 ± 0.88 (195)	3.90 ± 0.95 (195)*	3.55 ± 0.93 (156)	3.71 ± 0.91 (159)*	3.84 ± 0.84 (195)*
LGBTQIA2S-	4.15 ± 0.92 (305)	4.06 ± 0.98 (305)	3.69 ± 0.94 (254)	3.86 ± 0.89 (259)	3.96 ± 0.82 (305)
LGBTQIA2S+	3.82 ± 0.95 (63)**	3.67 ± 0.96 (63)**	3.42 ± 0.80 (47)	3.63 ± 0.85 (48)	3.69 ± 0.80 (63)*
White	4.20 ± 0.86 (199)	4.11 ± 0.93 (199)	3.73 ± 0.84 (167)	3.98 ± 0.78 (171)	4.03 ± 0.75 (199)
Hispanic/Latino	4.04 ± 0.91 (56)	3.95 ± 0.99 (56)	3.69 ± 0.92 (44)	3.68 ± 0.88 (45)*	3.89 ± 0.79 (56)
South Asian	3.64 ± 1.15 (24)**	3.57 ± 1.12 (24)**	3.37 ± 1.15 (20)	3.48 ± 1.18 (21)	3.48 ± 1.01 (24)***
Black/African American	3.79 ± 0.87 (27)*	3.56 ± 0.88 (27)**	3.21 ± 0.65 (25)***	3.28 ± 0.89 (26)***	3.47 ± 0.73 (27)***
East Asian	3.69 ± 0.96 (22)**	3.59 ± 0.91 (22)*	3.17 ± 1.10 (14)*	3.54 ± 0.74 (13)	3.63 ± 0.84 (22)*
Southeast Asian	4.36 ± 1.03 (17)	4.20 ± 1.11 (17)	4.26 ± 0.86 (13)*	4.21 ± 0.94 (13)	4.27 ± 0.83 (17)
Middle Eastern/N African	4.14 ± 0.92 (12)	4.08 ± 1.02 (12)	3.48 ± 0.84 (9)	3.82 ± 0.76 (9)	3.85 ± 0.79 (12)
Amer Indian/Alaska Nat	4.25 ± 0.66 (3)	4.08 ± 0.38 (3)	2.33 ± 0.11 (3)	3.00 ± 1.00 (3)*	3.41 ± 0.19 (3)
Full member	4.09 ± 0.95 (327)	3.99 ± 1.02 (327)	3.62 ± 0.92 (277)	3.78 ± 0.92 (283)	3.88 ± 0.84 (328)
Associate member	4.08 ± 0.75 (18)	4.11 ± 0.72 (18)	4.24 ± 0.77 (14)*	3.89 ± 0.64 (14)	4.05 ± 0.64 (18)
Trainee member	4.16 ± 0.73 (49)	4.06 ± 0.75 (49)	3.61 ± 0.81 (32)	3.97 ± 0.70 (33)	4.01 ± 0.67 (49)

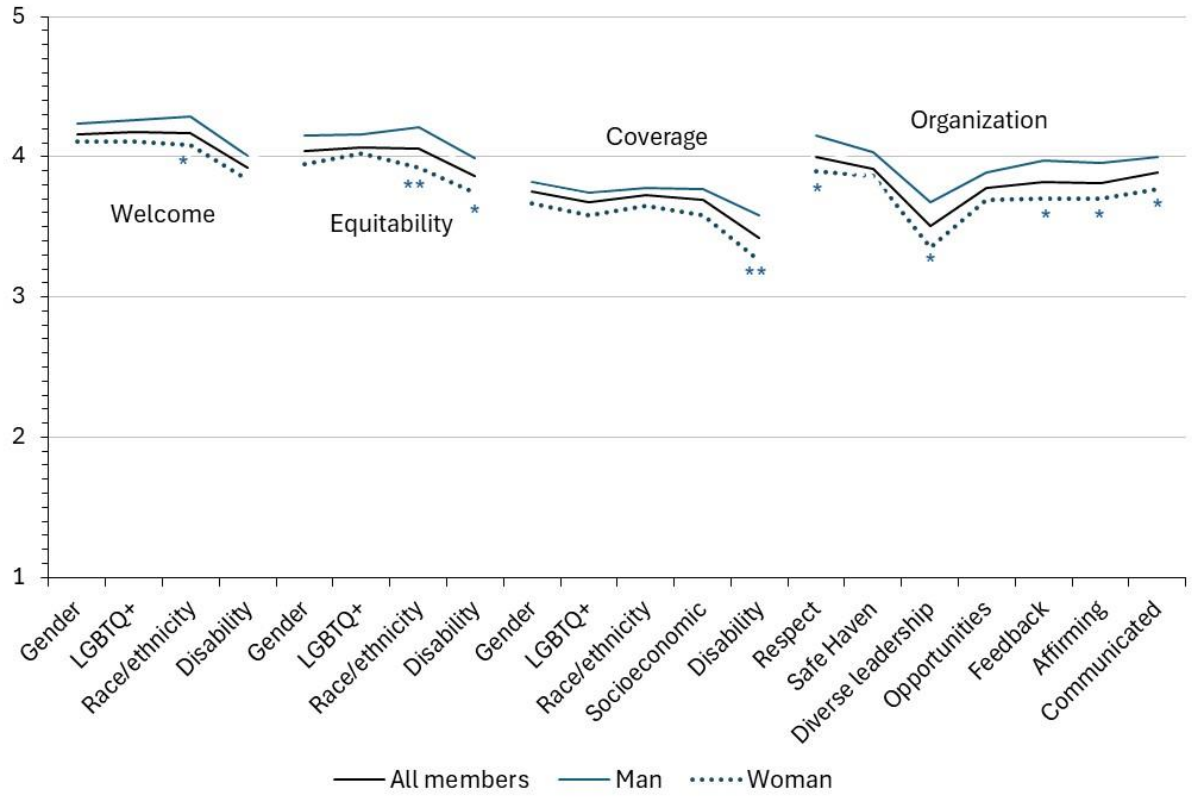
Mean agreement scores for the 4 Welcome items, 4 Equitability items, 5 Coverage items, and 7 Organization items, as well as Overall mean, are shown (mean ± standard deviation, with number of respondents shown in parentheses). Overall mean is the mean of the available 4 mean sub-scores. Statistical comparisons are made relative to Man, non-LGBTQIA2S+, White, and Full member respondents in the respective sections of the Table (, ≤0.05, **, ≤0.01, ***, ≤0.001).*

TABLE 5

	Query #1 Progress	Query #2 Needs	Query #3 Coverage	Query #4 General	TOTAL
Recognizing/supporting ACLP progress in DEIA	105	10	2	0	117
Advocating increased efforts for DEIA	9	36	48	15	108
Not advocating increased efforts for DEIA	6	11	13	13	43
Questioning annual meeting location	1	25	4	1	31
Raising leadership diversity issues	3	22	0	4	29
Urging more attention to disability/special needs	0	3	7	2	12
Urging increased attention to APPs	1	4	1	1	7

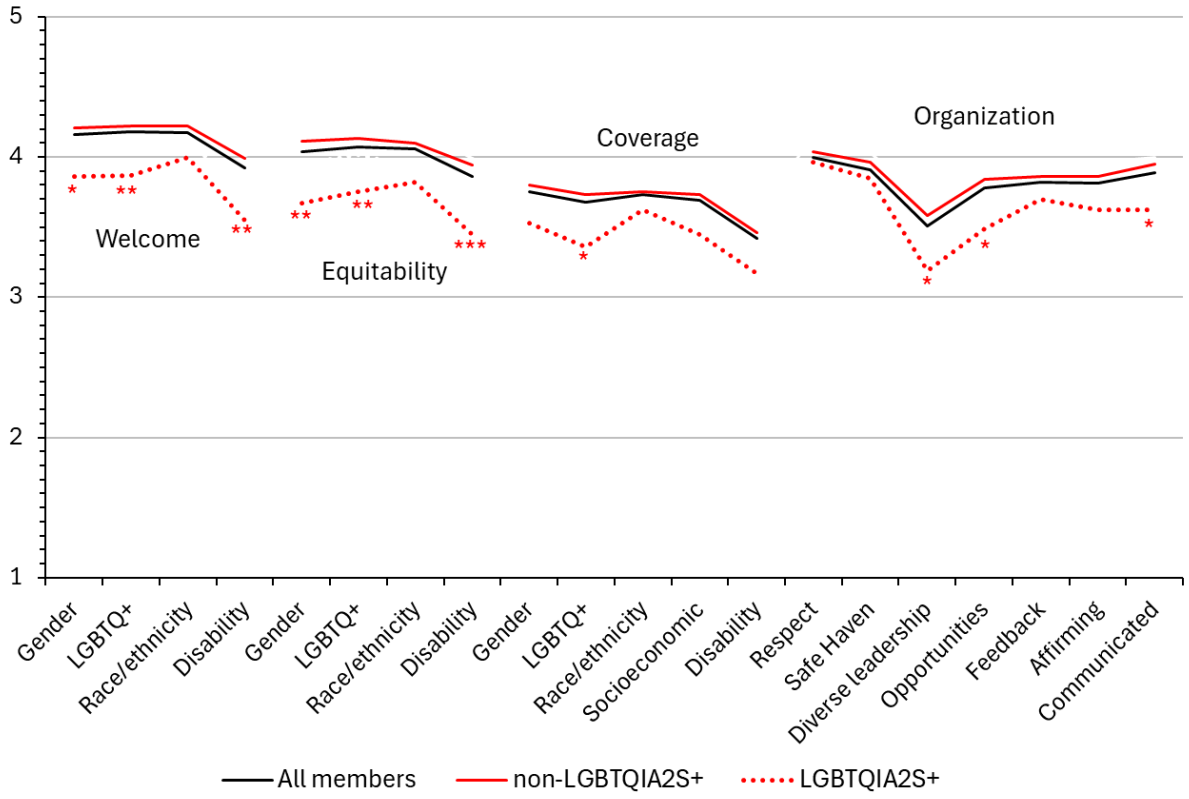
Themes expressed in responses to Query #1 through 4 are tabulated. A comment with more than 1 theme would be counted in more than one thematic area. The section "NOT ADVOCATING INCREASED EFFORTS FOR DEIA" includes comments arguing for increased tolerance of diverse viewpoints (see Supplemental Table S5).

FIGURE 1



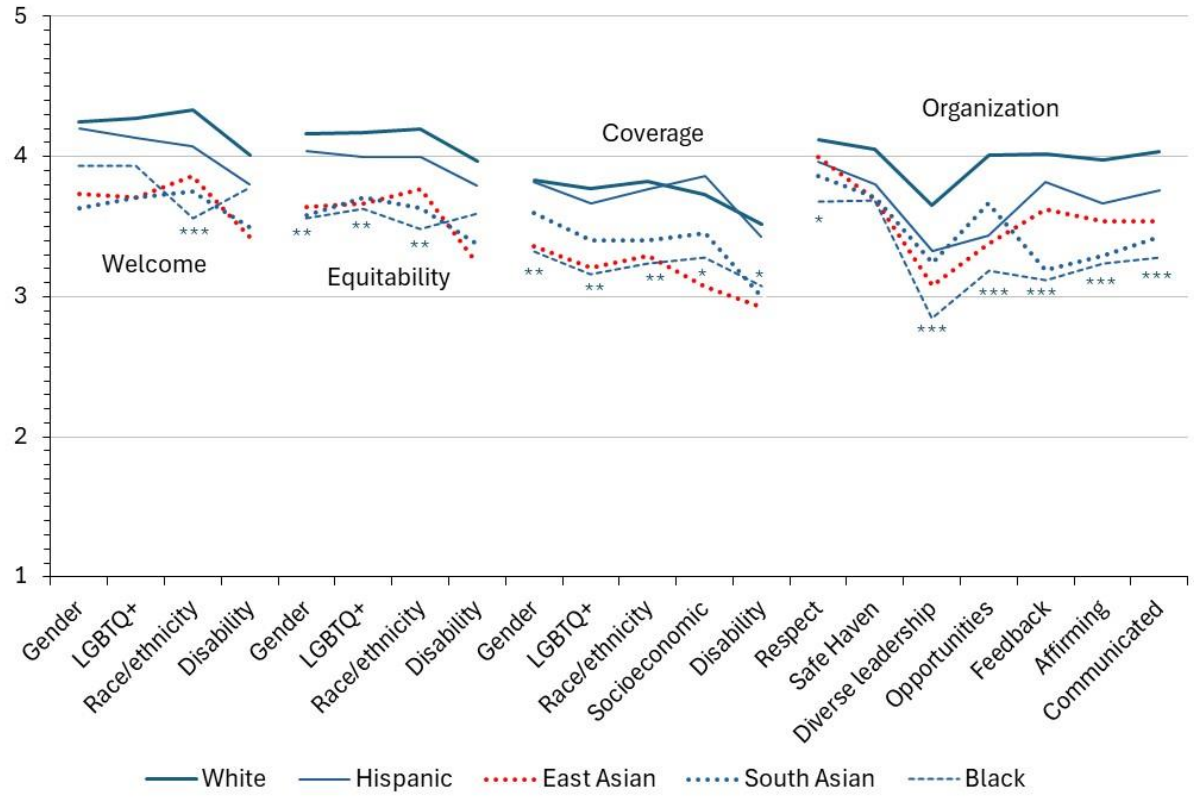
Agreement scores for 4 Welcome items, 4 Equitability items, 5 Coverage items, and 7 Organization items are plotted. Items with statistically significant difference between respondents identifying as Man vs Woman are indicated (, ≤0.05, **, ≤0.01, ***, ≤0.001). See also Supplemental Table S2.*

FIGURE 2



Agreement scores for 4 Welcome items, 4 Equitability items, 5 Coverage items, and 7 Organization items are plotted. LGBTQIA2S+ values which are significantly different from non-LGBTQIA2S+ values are indicated (, ≤0.05, **; ≤0.01, ***; ≤0.001). See also Supplemental Table S3.*

FIGURE 3



Agreement scores for 4 Welcome items, 4 Equitability items, 5 Coverage items, and 7 Organization items are plotted. Values from Black respondents that are significantly different from values from White respondents are indicated (, ≤0.05; **, ≤0.01; ***, ≤0.001). See also Supplemental Table S4.*

SUPPLEMENTAL TABLE S1: Response items

The survey included 20 items regarding attitudes towards the ACLP. These were rated "strongly disagree, disagree, neither, agree, strongly agree." These concerned the degree to which the ACLP was welcoming to specific groups, the degree to which the ACLP was equitable in its treatment of specific groups, the degree to which the ACLP adequately covered specific issues, and the degree to which ACLP met specific organizational goals. The survey also included 4 open-ended responses as shown.

WELCOME ITEMS	
I feel the ACLP is welcoming to:	Individuals of all gender identities Individuals with LGBTQIA2S+ identities Individuals of all races/ethnicities Individuals with disabilities
EQUITABILITY ITEMS	
I feel the ACLP is equitable in including and involving:	Individuals of all gender identities Individuals with LGBTQIA2S+ identities Individuals of all races/ethnicities Individuals with disabilities
COVERAGE ITEMS	
I feel that the coverage of the following issues in the Annual Meeting, the ACLP DEIA webpages, and other educational endeavors of the organization has been appropriate and adequate:	Gender healthcare inequities LGBTQIA2S+ healthcare inequities Racial / ethnic healthcare inequities Socioeconomic healthcare inequities Disability healthcare inequities
ORGANIZATION ITEMS	
Please indicate your agreement or disagreement with the following statements:	I feel respected and recognized within the ACLP The ACLP provides a safe space for discussion of issues of diversity, equity, inclusion, and accessibility ACLP leadership reflects the diversity of the organization The ACLP provides opportunities for advancement within the organization I have opportunities to give meaningful feedback about my experiences within the ACLP The ACLP creates an affirming environment for all members The ACLP has effectively communicated its commitment to diversity, equity, inclusion, and accessibility

OPEN-ENDED ITEMS

Please comment on ways in which you feel the ACLP has lived up to its goals of diversity, equity, inclusion, and accessibility:	Open-Ended Response Query #1
Please comment on ways in which you feel the ACLP can improve in achieving its goals of diversity, equity, inclusion, and accessibility:	Open-Ended Response Query #2
Please comment on how the ACLP can better meet the educational needs of its members about the topics above:	Open-Ended Response Query #3
Please make any comments you wish to add.	Open-Ended Response Query #4

SUPPLEMENTAL TABLE S2: Attitudes for all members, and by gender identity

This table illustrates mean scores for all members, followed by mean scores for individuals identifying as men versus women. All means are shown ± standard deviation; number of respondents is in parentheses. Scores are shown for all 20 attitude items. Not all respondents answered all items. Comparisons are pairwise t tests between scores for men vs women, with significant p values highlighted by shading. Cohen's d estimate of effect size is shown. %Appr is the percentage of subjects responding with "Agree" or "Strongly Agree" and is shown for each item.

		Member (all)	%Appr	Man	%Appr	Woman	%Appr	p	d
Welcome	Gender	4.16 ± 1.03 (394)	78.6%	4.24 ± 1.07 (177)	83.0%	4.11 ± 0.98 (195)	74.8%	0.224	0.126
	LGBTQ+	4.18 ± 0.97 (390)	78.4%	4.26 ± 0.99 (173)	84.3%	4.11 ± 0.92 (195)	73.8%	0.144	0.153
	Race/ethnicity	4.17 ± 0.96 (391)	78.7%	4.29 ± 0.95 (174)	84.4%	4.08 ± 0.94 (195)	74.3%	0.034	0.221
	Disability	3.92 ± 0.99 (389)	63.4%	4.01 ± 1.00 (172)	69.1%	3.84 ± 0.96 (195)	57.4%	0.089	0.178
Equitable	Gender	4.04 ± 1.07 (394)	72.3%	4.15 ± 1.08 (177)	78.5%	3.95 ± 1.04 (195)	67.6%	0.072	0.187
	LGBTQ+	4.07 ± 1.02 (390)	72.8%	4.16 ± 1.04 (173)	78.6%	4.02 ± 0.98 (195)	68.7%	0.185	0.139
	Race/ethnicity	4.06 ± 1.02 (391)	73.4%	4.21 ± 0.96 (174)	81.0%	3.92 ± 1.06 (195)	67.1%	0.007	0.284
	Disability	3.86 ± 1.02 (389)	60.1%	3.99 ± 1.02 (173)	68.2%	3.74 ± 1 (194)	52.0%	0.018	0.250
Coverage	Gender	3.75 ± 0.96 (323)	61.9%	3.82 ± 0.89 (149)	65.1%	3.67 ± 1.02 (156)	59.6%	0.186	0.151
	LGBTQ+	3.68 ± 0.98 (321)	56.3%	3.74 ± 0.92 (147)	60.5%	3.58 ± 1.02 (156)	51.9%	0.159	0.162
	Race/ethnicity	3.73 ± 1.01 (321)	61.6%	3.78 ± 0.96 (147)	64.6%	3.65 ± 1.05 (156)	59.6%	0.247	0.133
	Socioeconomic	3.69 ± 1.06 (321)	57.9%	3.77 ± 1.02 (147)	61.9%	3.58 ± 1.11 (156)	54.4%	0.134	0.173
	Disability	3.42 ± 1.08 (320)	43.4%	3.58 ± 1.03 (147)	49.6%	3.26 ± 1.12 (155)	38.0%	0.010	0.297
Organization	Respect	4.00 ± 0.96 (329)	75.0%	4.15 ± 0.87 (152)	81.5%	3.9 ± 0.98 (158)	69.6%	0.018	0.271
	Safe Haven	3.91 ± 1.01 (327)	71.5%	4.03 ± 0.99 (150)	80.0%	3.86 ± 0.98 (158)	66.4%	0.127	0.174
	Diverse leadership	3.51 ± 1.16 (326)	53.3%	3.68 ± 1.15 (149)	61.7%	3.35 ± 1.13 (158)	46.2%	0.012	0.287
	Opportunities	3.78 ± 1.01 (325)	63.6%	3.89 ± 0.97 (149)	67.7%	3.69 ± 1.04 (158)	60.7%	0.079	0.201
	Feedback	3.82 ± 1.03 (326)	66.2%	3.97 ± 0.96 (149)	74.4%	3.7 ± 1.09 (159)	60.3%	0.027	0.253
	Affirming	3.81 ± 1.03 (325)	66.7%	3.96 ± 0.97 (149)	74.4%	3.7 ± 1.03 (157)	60.5%	0.025	0.257
	Communicated	3.89 ± 1.00 (324)	68.2%	4 ± 0.90 (150)	74.0%	3.77 ± 1.07 (156)	63.4%	0.043	0.232

SUPPLEMENTAL TABLE S3: Attitudes by LGBTQIA2S+ orientation

This table illustrates mean scores for LGBTQIA2S+ versus non-LGBTQIA2S+. All means are shown ± standard deviation; number of respondents is in parentheses. Scores are shown for all 20 attitude items. Not all respondents answered all items. Comparisons are pairwise t tests between scores for LGBTQIA2S+ versus non-LGBTQIA2S+, with significant p values highlighted by shading. Cohen's d estimate of effect size is shown. %Appr is the percentage of subjects responding with "Agree" or "Strongly Agree" and is shown for each item.

		LGBTQIA2S+	%Appr	non-LGBTQIA2S+	%Appr	p	d
Welcome	Gender	3.86 ± 1.18 (63)	71.4%	4.21 ± 1.01 (305)	79.6%	0.015	0.338
	LGBTQ+	3.87 ± 1.12 (63)	74.6%	4.22 ± 0.94 (301)	78.7%	0.010	0.357
	Race/ethnicity	4.00 ± 0.90 (62)	74.1%	4.22 ± 0.96 (303)	80.1%	0.102	0.229
	Disability	3.55 ± 0.93 (62)	53.2%	3.99 ± 1.00 (302)	64.9%	0.002	0.441
Equitable	Gender	3.67 ± 1.21 (63)	58.7%	4.11 ± 1.04 (305)	75.4%	0.003	0.417
	LGBTQ+	3.75 ± 1.16 (63)	61.9%	4.13 ± 0.99 (301)	74.7%	0.007	0.378
	Race/ethnicity	3.82 ± 0.91 (62)	62.9%	4.10 ± 1.05 (303)	75.2%	0.052	0.272
	Disability	3.45 ± 0.95 (62)	41.9%	3.94 ± 1.03 (301)	63.4%	<.001	0.480
Coverage	Gender	3.53 ± 0.90 (47)	51.0%	3.80 ± 0.98 (254)	64.9%	0.080	0.279
	LGBTQ+	3.36 ± 0.91 (47)	40.4%	3.73 ± 0.99 (252)	59.5%	0.020	0.372
	Race/ethnicity	3.62 ± 0.92 (47)	57.4%	3.75 ± 1.04 (252)	63.4%	0.428	0.126
	Socioeconomic	3.45 ± 0.92 (47)	48.9%	3.73 ± 1.10 (252)	60.3%	0.104	0.259
	Disability	3.17 ± 0.91 (47)	27.6%	3.46 ± 1.12 (251)	47.0%	0.057	0.267
Organization	Respect	3.96 ± 0.96 (48)	75.0%	4.04 ± 0.95 (258)	75.9%	0.594	0.084
	Safe Haven	3.85 ± 1.04 (47)	76.5%	3.96 ± 0.98 (257)	72.7%	0.471	0.115
	Diverse leadership	3.19 ± 1.20 (47)	40.4%	3.58 ± 1.14 (256)	56.6%	0.036	0.334
	Opportunities	3.49 ± 1.01 (47)	57.4%	3.84 ± 1.02 (256)	65.6%	0.031	0.343
	Feedback	3.7 ± 0.83 (47)	59.5%	3.86 ± 1.08 (257)	68.8%	0.343	0.151
	Affirming	3.62 ± 1.01 (47)	65.9%	3.86 ± 1.03 (255)	67.8%	0.133	0.239
	Communicated	3.62 ± 0.92 (47)	55.3%	3.95 ± 1.01 (255)	71.7%	0.040	0.328

SUPPLEMENTAL TABLE S4A, B, C: Attitudes by racial/ethnic subgroup

These tables illustrate mean item scores for respondents identifying as White (with no other identity), East Asian, Southeast Asian, South Asian, Black/African American, Hispanic, and Middle Eastern. All means are shown ± standard deviation; number of respondents is in parentheses. Scores are shown for all 20 attitude items. Not all respondents answered all items. Comparisons are pairwise t tests between scores for respondents identifying as White only versus each other ethnic group, with significant p values highlighted by shading. Cohen's d estimate of effect size is shown. %Appr is the percentage of subjects responding with "Agree" or "Strongly Agree" and is shown for each item.

Supplemental Table S4A: Attitudes for respondents identifying as White vs respondents identifying as East Asian or Southeast Asian

		White	%Appr	East Asian	%Appr	p	d	Southeast Asian	%Appr	p	d
Welcome	Gender	4.25 ± 0.96 (199)	82.4%	3.73 ± 1.31 (22)	68.1%	0.021	-0.521	4.35 ± 1.05 (17)	88.2%	0.680	0.104
	LGBTQ+	4.27 ± 0.90 (196)	83.1%	3.71 ± 1.00 (21)	66.6%	0.009	-0.610	4.41 ± 1.06 (17)	88.2%	0.542	0.154
	Race/ethnicity	4.33 ± 0.82 (196)	83.6%	3.86 ± 0.94 (22)	72.7%	0.015	-0.552	4.41 ± 1.00 (17)	94.1%	0.689	0.101
	Disability	4.01 ± 0.94 (195)	67.1%	3.43 ± 0.97 (21)	52.3%	0.008	-0.612	4.29 ± 1.10 (17)	82.3%	0.244	0.296
Equitable	Gender	4.16 ± 1.02 (199)	78.3%	3.64 ± 1.13 (22)	59.0%	0.026	-0.503	4.18 ± 1.13 (17)	76.4%	0.937	0.020
	LGBTQ+	4.17 ± 0.96 (197)	78.6%	3.67 ± 1.01 (21)	61.9%	0.024	-0.522	4.29 ± 1.16 (17)	76.4%	0.624	0.124
	Race/ethnicity	4.2 ± 0.92 (196)	78.0%	3.77 ± 0.86 (22)	72.7%	0.041	-0.463	4.24 ± 1.2 (17)	82.3%	0.880	0.038
	Disability	3.97 ± 0.97 (196)	65.3%	3.24 ± 0.99 (21)	38.0%	0.001	-0.755	4.12 ± 1.16 (17)	70.5%	0.568	0.145
Coverage	Gender	3.83 ± 0.91 (167)	65.8%	3.36 ± 1.15 (14)	50.0%	0.072	-0.504	4.38 ± 0.76 (13)	84.6%	0.033	0.618
	LGBTQ+	3.77 ± 0.93 (166)	61.4%	3.21 ± 1.05 (14)	42.8%	0.037	-0.584	4.23 ± 0.92 (13)	69.2%	0.085	0.499
	Race/ethnicity	3.82 ± 0.89 (166)	65.0%	3.29 ± 1.20 (14)	50.0%	0.039	-0.578	4.31 ± 0.85 (13)	76.9%	0.059	0.547
	Socioeconomic	3.73 ± 1.02 (166)	60.2%	3.07 ± 1.38 (14)	42.8%	0.025	-0.630	4.23 ± 0.92 (13)	69.2%	0.092	0.488
	Disability	3.52 ± 1.04 (165)	47.8%	2.93 ± 1.07 (14)	28.5%	0.045	-0.563	4.15 ± 0.98 (13)	61.5%	0.034	0.616
Organization	Respect	4.12 ± 0.87 (171)	80.7%	4 ± 0.91 (13)	76.9%	0.628	-0.140	4.31 ± 1.03 (13)	76.9%	0.470	0.208
	Safe Haven	4.05 ± 0.88 (169)	79.2%	3.69 ± 0.85 (13)	61.5%	0.159	-0.407	4.38 ± 0.96 (13)	84.6%	0.199	0.371
	Diverse leadership	3.65 ± 1.05 (168)	58.3%	3.08 ± 1.11 (13)	46.1%	0.060	-0.545	4 ± 1.15 (13)	69.2%	0.260	0.325
	Opportunities	4.01 ± 0.94 (168)	75.0%	3.38 ± 0.76 (13)	53.8%	0.021	-0.670	3.92 ± 1.11 (13)	69.2%	0.748	-0.093
	Feedback	4.02 ± 0.93 (169)	74.5%	3.62 ± 0.76 (13)	61.5%	0.126	-0.443	4.23 ± 0.92 (13)	84.6%	0.441	0.222
	Affirming	3.98 ± 0.94 (168)	76.1%	3.54 ± 0.77 (13)	53.8%	0.101	-0.475	4.38 ± 0.96 (13)	84.6%	0.141	0.426
	Communicated	4.04 ± 0.87 (169)	75.7%	3.54 ± 1.05 (13)	61.5%	0.051	-0.566	4.31 ± 1.03 (13)	76.9%	0.298	0.300

Supplemental Table S4B: Attitudes for respondents identifying as White vs respondents identifying as South Asian or Black/African American

		White	%Appr	South Asian	%Appr	p	d	Black/ African American	%Appr	p	d
Welcome	Gender	4.25 ± 0.96 (199)	82.4%	3.63 ± 1.31 (24)	62.5%	0.032	-0.621	3.93 ± 0.99 (27)	66.6%	0.104	-0.335
	LGBTQ+	4.27 ± 0.90 (196)	83.1%	3.71 ± 1.30 (24)	70.8%	0.050	-0.590	3.93 ± 0.91 (27)	55.5%	0.065	-0.381
	Race/ethnicity	4.33 ± 0.82 (196)	83.6%	3.75 ± 1.15 (24)	70.8%	0.002	-0.666	3.56 ± 1.25 (27)	59.2%	<.001	-0.869
	Disability	4.01 ± 0.94 (195)	67.1%	3.50 ± 1.10 (24)	54.1%	0.015	-0.529	3.78 ± 0.89 (27)	48.1%	0.230	-0.247
Equitable	Gender	4.16 ± 1.02 (199)	78.3%	3.58 ± 1.28 (24)	62.5%	0.012	-0.545	3.56 ± 1.01 (27)	44.4%	0.004	-0.589
	LGBTQ+	4.17 ± 0.96 (197)	78.6%	3.71 ± 1.19 (24)	62.5%	0.031	-0.468	3.63 ± 0.88 (27)	44.4%	0.006	-0.569
	Race/ethnicity	4.20 ± 0.92 (196)	78.0%	3.63 ± 1.17 (24)	58.3%	0.006	-0.601	3.48 ± 1.22 (27)	55.5%	0.006	-0.743
	Disability	3.97 ± 0.97 (196)	65.3%	3.38 ± 1.17 (24)	41.6%	0.006	-0.602	3.59 ± 0.84 (27)	44.4%	0.054	-0.398
Coverage	Gender	3.83 ± 0.91 (167)	65.8%	3.60 ± 1.14 (20)	65.0%	0.309	-0.241	3.32 ± 0.74 (25)	44.0%	0.009	-0.567
	LGBTQ+	3.77 ± 0.93 (166)	61.4%	3.40 ± 1.18 (20)	55.0%	0.111	-0.379	3.16 ± 0.80 (25)	28.0%	0.002	-0.659
	Race/ethnicity	3.82 ± 0.89 (166)	65.0%	3.40 ± 1.23 (20)	60.0%	0.154	-0.448	3.24 ± 1.09 (25)	48.0%	0.004	-0.627
	Socioeconomic	3.73 ± 1.02 (166)	60.2%	3.45 ± 1.31 (20)	60.0%	0.256	-0.270	3.28 ± 0.89 (25)	40.0%	0.036	-0.452
	Disability	3.52 ± 1.04 (165)	47.8%	3.00 ± 1.37 (20)	40.0%	0.045	-0.477	3.08 ± 0.70 (25)	20.0%	0.045	-0.434
Organization	Respect	4.12 ± 0.87 (171)	80.7%	3.86 ± 1.15 (21)	71.4%	0.208	-0.292	3.68 ± 0.98 (25)	56.0%	0.021	-0.497
	Safe Haven	4.05 ± 0.88 (169)	79.2%	3.71 ± 1.27 (21)	61.9%	0.248	-0.362	3.69 ± 1.19 (26)	61.5%	0.149	-0.387
	Diverse leadership	3.65 ± 1.05 (168)	58.3%	3.24 ± 1.44 (21)	52.3%	0.214	-0.378	2.85 ± 1.31 (26)	30.7%	<.001	-0.740
	Opportunities	4.01 ± 0.94 (168)	75.0%	3.67 ± 1.06 (21)	61.9%	0.122	-0.359	3.19 ± 0.98 (26)	38.4%	<.001	-0.861
	Feedback	4.02 ± 0.93 (169)	74.5%	3.19 ± 1.47 (21)	47.6%	<.001	-0.831	3.12 ± 0.90 (26)	38.4%	<.001	-0.978
	Affirming	3.98 ± 0.94 (168)	76.1%	3.29 ± 1.27 (21)	47.6%	0.023	-0.707	3.24 ± 1.01 (25)	36.0%	<.001	-0.779
	Communicated	4.04 ± 0.87 (169)	75.7%	3.43 ± 1.28 (21)	52.3%	0.045	-0.660	3.28 ± 1.13 (25)	40.0%	<.001	-0.835

Supplemental Table S4C: Attitudes for respondents identifying as White vs respondents identifying as Hispanic or Middle Eastern

		White	%Appr	Hispanic	%Appr	p	d	Middle Eastern	%Appr	p	d
Welcome	Gender	4.25 ± 0.96 (199)	82.4%	4.20 ± 1.01 (56)	75.0%	0.711	-0.056	4.25 ± 0.86 (12)	75.0%	0.997	-0.001
	LGBTQ+	4.27 ± 0.90 (196)	83.1%	4.13 ± 1.01 (56)	73.2%	0.302	-0.157	4.17 ± 1.03 (12)	75.0%	0.702	-0.114
	Race/ethnicity	4.33 ± 0.82 (196)	83.6%	4.07 ± 1.04 (56)	69.6%	0.096	-0.290	4.25 ± 0.75 (12)	83.3%	0.755	-0.093
	Disability	4.01 ± 0.94 (195)	67.1%	3.80 ± 0.99 (56)	55.3%	0.156	-0.216	3.92 ± 1.16 (12)	66.6%	0.743	-0.097
Equitable	Gender	4.16 ± 1.02 (199)	78.3%	4.04 ± 1.07 (56)	66.0%	0.443	-0.116	4.08 ± 1.16 (12)	75.0%	0.813	-0.070
	LGBTQ+	4.17 ± 0.96 (197)	78.6%	4.00 ± 1.10 (55)	65.4%	0.257	-0.173	4.17 ± 1.03 (12)	75.0%	0.984	-0.006
	Race/ethnicity	4.20 ± 0.92 (196)	78.0%	4.00 ± 1.09 (56)	67.8%	0.175	-0.206	4.17 ± 0.83 (12)	75.0%	0.906	-0.035
	Disability	3.97 ± 0.97 (196)	65.3%	3.79 ± 1.00 (56)	53.5%	0.205	-0.193	3.92 ± 1.16 (12)	66.6%	0.844	-0.059
Coverage	Gender	3.83 ± 0.91 (167)	65.8%	3.82 ± 0.94 (44)	63.6%	0.958	-0.009	3.56 ± 0.88 (9)	33.3%	0.386	-0.297
	LGBTQ+	3.77 ± 0.93 (166)	61.4%	3.67 ± 0.91 (43)	55.8%	0.570	-0.097	3.56 ± 0.88 (9)	33.3%	0.512	-0.225
	Race/ethnicity	3.82 ± 0.89 (166)	65.0%	3.77 ± 1.04 (43)	65.1%	0.744	-0.056	3.56 ± 0.88 (9)	33.3%	0.391	-0.294
	Socioeconomic	3.73 ± 1.02 (166)	60.2%	3.86 ± 1.02 (44)	68.1%	0.459	0.126	3.63 ± 0.91 (8)	37.5%	0.766	-0.108
	Disability	3.52 ± 1.04 (165)	47.8%	3.43 ± 1.14 (44)	45.4%	0.645	-0.078	3.25 ± 0.88 (8)	25.0%	0.480	-0.257
Organization	Respect	4.12 ± 0.87 (171)	80.7%	3.96 ± 0.85 (45)	71.1%	0.253	-0.192	4.00 ± 1.00 (9)	77.7%	0.684	-0.139
	Safe Haven	4.05 ± 0.88 (169)	79.2%	3.80 ± 0.94 (45)	64.4%	0.095	-0.281	4.13 ± 0.83 (8)	75.0%	0.823	0.081
	Diverse leadership	3.65 ± 1.05 (168)	58.3%	3.33 ± 1.20 (45)	42.2%	0.080	-0.295	3.38 ± 1.06 (8)	50.0%	0.465	-0.265
	Opportunities	4.01 ± 0.94 (168)	75.0%	3.44 ± 1.07 (45)	44.4%	0.002	-0.581	3.63 ± 1.18 (8)	62.5%	0.266	-0.404
	Feedback	4.02 ± 0.93 (169)	74.5%	3.82 ± 0.96 (45)	62.2%	0.202	-0.215	4.13 ± 0.83 (8)	75.0%	0.763	0.109
	Affirming	3.98 ± 0.94 (168)	76.1%	3.67 ± 1.02 (45)	55.5%	0.052	-0.328	4.25 ± 0.70 (8)	87.5%	0.430	0.286
	Communicated	4.04 ± 0.87 (169)	75.7%	3.76 ± 0.95 (45)	64.4%	0.058	-0.320	3.88 ± 0.83 (8)	62.5%	0.599	-0.190

SUPPLEMENTAL TABLE S5

Randomly selected comments are shown for the largest thematic areas. Duplicate or unclear comments were omitted, as were any comments referring to the identity of the respondent. Obvious misspellings and typographic errors were corrected. A comment with more than 1 theme may appear in more than one section. The section "NOT ADVOCATING INCREASED EFFORTS FOR DEIA" includes comments arguing for increased tolerance of diverse viewpoints.

RECOGNIZING/SUPPORTING SOME ACLP PROGRESS IN DEIA

It is doing a fine job.

Welcoming, inclusive culture and topics.

Diverse content and lots of DEI in conference offerings

Never seen any type of discrimination

Attempts have been made to include more diversity-oriented presentations at meetings

By starting to have these surveys!!! but I think for last 15-20 years, it has done quite well, long before this DEIA stuff. Every year has seen improvements and growth. before 2000, well, ok, most leaders were white, males from northeast!!! but look at us now!

I think the organization is inclusive

Making it a part of the submission process

Inclusivity in messages and emails

Very inclusive organization

Encouraging DEI focus with submissions

ACLP's DEIA initiatives aim to create an environment that respects and values diversity while ensuring equitable access to resources and opportunities.

Strongest testimony is the ACLP yearly conference attended by a more than 1000 attendees from diverse backgrounds

Multiple sessions at annual ACLP conference reflect DEI concerns.

This organization has recognized and discussed microaggression, race and medicine, and appears to want to continue to expand discussion and impact to practice and patient care

I have always felt included

There seems to have been a smooth inclusiveness over the past 10-15 years which is seamless within the organization and our meeting.

I feel that ACLP, and psychiatry in general, are more ethically focused and maintain a high regard for the importance of individual autonomy and expression.

In all my years as a member, I feel that the ACLP has lived up to its DEI goals.

Open, welcoming

Not being actively racist or discriminatory towards others.

Of all the organizations to which I belong, ACLP is definitely the most diverse in leadership, members, presentations, etc.

Through the dedicated and strong work of the DEI subcommittee.

Welcoming SIGs and caucuses for various identities. Mentorship with option to specify individual identities. DEIA statement evaluated for meeting submissions

ACLP has created a DEIA Subcommittee, and is working to create more DEIA clinical resources for members.

Generally very diverse, open, equitable

Lots of lectures and info on sexual identity issues.

When I attend the annual meeting, I meet attendees and presenters from diverse ethnicities, races, cultures, religions and gender identities.

Being polite and respectful is universal

Representation of women has improved over the past 35 years.

It is doing this survey to find out what it doesn't know

As it pertains to gender inclusivity, ACLP has been welcoming and acceptable in terms of the activity of the women's caucus, women in leaderships roles and attention to mental health issues unique to the female gender.

I think it is hard for ACLP to have these goals - not much control over membership

ADVOCATING INCREASED EFFORTS FOR DEIA

I think it needs to do better

I do appreciate that there seems to have been an effort to diversify the actual programming/presentations at meetings in recent years, in terms of content and presenters. I still do not think that this diversity is representative of the academy as a whole and certainly not representative of the populations we serve, but it is a move in a good direction.

ACLP has not fully embraced any clear goals around diversity, equity, inclusion, and accessibility. If it has, these goals have not been made clear or communicated accordingly to the larger membership. The core leadership of the organization does not appear to be as racially/ethnically diverse as it could be. I do not see any prominent African American, disabled, gender non-conforming, Hispanic, or clearly marginalized CL psychiatrists represented in leadership anywhere within the organization.

ACLP has not really made it clear that they have goals with regard to diversity, equity and inclusion.

Less representation of the most socioeconomically disadvantaged groups in our membership.

More actively addressing inequalities versus tacitly acknowledging

Outreach to members from underrepresented groups

Need to increase opportunities for trainees from multiple backgrounds

Outreach to students/doctors of color

More outreach to those of us who are under-represented minorities in Medicine, and C-L Psychiatry in particular.

The meeting is not particularly welcoming.

Develop action items based on the survey results and an action plan for implementation.

Include more presentations at the annual meeting that touch on diversity issues.

Additional discussions of the topic, address of physician and provider mental health

More education and promotion of awareness about diversity, equity, inclusion, and accessibility

Active recruitment of members

Diversify award winners, more emphasis on mainstreaming care of vulnerable populations in all educational offerings (webinars etc), financial support / travel award for URM to attend annual meeting and preconference courses

There is limited diversity in terms of ethnic and historically marginalized groups, both in participation (active membership) and topics/challenges unique to these groups.

Surveys and conversation not backed by action are meaningless.

More speakers of diverse backgrounds including neurodiverse backgrounds.

1. More diverse/inclusive leadership and board. *EDI Metrics and Goals: Set clear, measurable EDI goals, and hold leadership accountable for achieving them. Periodically review and update policies to ensure they align with EDI principles. 2. Inclusive Curriculum /workshops / presentations: Incorporate content that reflects the experiences, health disparities, and cultural needs of diverse populations, including race, ethnicity, gender, sexual orientation, and disability [https://www.sciencedirect.com/science/article/pii/S2667296024000235]. 3. Cultural Humility and Responsive Care Training: Offer training on cultural sensitivity and bias awareness in the context of CL Psych on annual meetings. 4. Increase Diversity for Mentorship/Programs: mentors from diverse backgrounds to provide role models for members from underrepresented groups. Develop mentorship initiatives specifically aimed at supporting members from underrepresented groups, providing guidance in academics, career development, and well-being. 5. Peer Support Networks: Promote the creation of affinity groups or networks for members of diverse backgrounds to build community and offer mutual support. 6. Promote awareness of EDI issues through events, seminars, and campaigns that celebrate diversity and educate about inclusion. 7. For annual meetings, location is key is to allow/create inclusive physical and social spaces where all members feel welcomed, including gender-neutral restrooms, quiet rooms for prayer or meditation, and disability-friendly facilities. 8. Foster a culture of using inclusive language in all communications and educational materials to reflect respect for all identities.

The ACLP has done a wonderful job in reaching DEI goals but more needs to be done. This survey is a wonderful start and may provide some suggestions on how to further provide and nurture our diverse community.

Please keep pushing the needle on DEiA. The field of CL psychiatry can benefit from ongoing active effort to diversify the field

Again, this has improved significantly from years ago, but there is still a long way to go. THANK YOU to all of you who are working on this.

NOT ADVOCATING INCREASED EFFORTS FOR DEIA

Go back to treating everyone as an individual and not as a group member whose identity is defined by their race or sex/gender or other group.

Feel the ACLP can be more accepting of people of different political views and not make members uncomfortable if they do not agree with the majority political views of the ACLP and not picking speakers that only speak to a particular political party.

I believe we must return to hard science; this means any research that includes diversity goals must be supported; we cannot include presentations or papers that are just about DEI but do not advance science.

Be more accepting and tolerant of members who may have views and opinions that differ from the majority or status quo.

By not getting too hung up on the subject — I think people of all genders, races, abilities and disabilities will come to the fore through their enthusiasm and preparedness to volunteer. I don't see barriers nor prejudice in the Academy.

Be more tolerant of differing opinions and not just those of the majority membership.

They shouldn't - this isn't within the purview of the ACLP. Focus on clinical education.

Beware of the risk of over-emphasizing certain slices of the DEIA concerns at the cost of diminishing work directed at clinical problems we all deal with day-by-day that affect far more patients.

Be more accepting and tolerant. This includes being open to hearing multiple viewpoints and not assuming that everyone in the organization is progressive and left-leaning. Those of us that have more conservative views do not feel welcomed or comfortable, especially during annual meetings. Speakers at annual meetings should represent a diverse array of viewpoints to stimulate healthy scientific discourse, not just reinforce the same opinions and perspectives held by the majority of academy members. The organization needs to do better to represent all of its members, not just the loudest majority.

While DEI is important, I would welcome more clinically oriented presentations as the pendulum has flung too far into social issues.

The overemphasis of DEI issues, too often in place of C-L scientific content, has greatly diminished the value of membership and attendance at the Annual Meeting. Members with conservative political views are marginalized and are not welcomed.

QUESTIONING ANNUAL MEETING LOCATION

Have annual meetings in states that don't discriminate on agency of one's own body.

Improving location of meetings

Ensure equity in evaluation of conference submissions that may need to be pre-recorded or presented remotely. For example, a pregnant presenter may not be able to safely travel to jurisdictions with restrictions in maternal healthcare. Such a presenter should not be overlooked for conference participation because of these accommodations.

The choice of locations for annual meetings has seemed to prioritize states that have aggressively attacked DEI values, and in some cases instituted laws which may make diverse members of the academy feel uncomfortable visiting in person or economically supporting these states. I think the academy could be more mindful of these members when choosing locations in the future.

Offer conferences in safer settings

Holding meetings in states that do not provide address to reproductive healthcare, including abortion, significantly adversely affects those of reproductive age. I would not feel safe attending a conference in a state where I cannot receive emergency reproductive healthcare if needed.

It would be beneficial if the annual conference were held in a state without biased laws. I personally do not want to spend money and time supporting economies in Texan or Florida.

We need to have conferences in locations where everyone feels safe. This is a major problem and I don't feel like we've had a good solution.

Making the meeting in places like Florida or Texas where so many of our members are unwelcome or feel in danger should not be done, particularly in today's political climate.

Stop scheduling the meetings in states that are unsafe or unwelcoming for marginalized groups

Consideration of locations chosen for annual conferences where there may be hesitation from marginalized communities to attend based on legislation against these communities.

Having meetings in places where there are laws threatening the autonomy of LGBTQ+ people and those who are pregnant while not providing the opportunity to present virtually is unconscionable. As new meeting locations are selected, they should be in places that are welcoming to all of our members, including those with diverse gender identities and those who are pregnant -- these members are at risk of receiving sub-standard or no care in

the event of a medical emergency in some states. When meeting locations have already been selected and deposits paid, there should be reasonable accommodations made for those who do not feel safe traveling to meetings to be able to participate to the fullest extent possible.

More thought to conference location and whether it welcomes all members, DEI statements for presentations could be more specific/guided to act as a tool of education or to inspire more thought from submitters.

1. Transparency in leadership practices 2. Having more diverse speakers and programming during annual meetings 3. Creating space for those from minoritized backgrounds to have leadership roles within ACLP 4. Not hosting meetings in places where members feel threatened or unwelcome

If having a meeting in a state hostile to certain forms of medical care or various individuals, please do more to acknowledge that while ACLP is politically neutral, you still care about members' perceived safety. Also, the DEI statements for abstracts are kind of useless. It's an open secret. It comes off as hypocritical to have us write these statements implying that ACLP is conscientiously pro-DEI while also claiming that ACLP can't possibly have an opinion about the anti-DEI agendas of states where the meeting is held. I don't think you can have it both ways.

I think ACLP should reconsider where they hold meetings, as there are some places where people don't feel they would be welcome and various pieces of legislation that have been enacted that could potentially impact the safety of attendees, as well limit their ability to engage with the organization. I also feel that ACLP should consider having a more diverse repertoire of speakers - most of the time, it seems that the speakers are generally the same people or from the same institutions; lots of other institutions don't seem well-represented and creates a sense of elitism and favoritism. Emphasizing the importance of DEIA in the academic setting and allowing early-career psychiatrists more opportunities within the organization, as well as valuing more qualitative DEIA work in the CL setting.

Listen to members with lived experience and also consider conference location and accessibility

Having the meetings at locations where everyone can feel safe. While I appreciate the educational content on this, I do have concerns about the physical location of the meetings.

Include these identities in presenters and presentation content. This might be easier if these populations felt safe or were better able to attend your conferences. Offering virtual presentation options may also help. The cost of attending meetings in person, even if you do feel safe going, is astronomical.

RAISING LEADERSHIP ISSUES

I'd like to see a more diverse leadership panel to include a good variety of people of different genders, ethnicities, and ability levels.

More significant inclusion of members of historically and intentionally excluded groups in leadership

Promote acceptance of IMGs into psychiatry residency programs with the long-term goal of increasing minority representation within the CL field (IMGs have a higher rate of pursuing fellowship). I also think it would be nice to see more minorities in positions of leadership within ACLP and in CL fellowship programs faculty.

Could improve processes for nominating and selecting the board members

More transparency about structure of ACLP, deliberate inclusion of all identities/abilities

More interest in including physicians of color in leadership/interest groups/etc.

Thinking about pipelines to include more diverse leadership. Encouraging educational material on website with DEIA focus

Participation in leadership and visible positions

ACLP can do a lot more work in incorporating DEIA into its leadership and processes, especially in regards to including members in decision-making, removing unnecessary barriers to FACLP status, and democratizing the elections and leadership selection process.

Consciously recruit ethnic and gender diverse individuals into prominent positions in executive leadership and drive initiatives to highlight those contributions (both in diversity and clinical leadership as well as areas of expertise).

Communication is key. Diversity in leadership representation as well as goals which are aimed at attracting more diverse members into leadership.

We need more diverse leadership, and to support the pipeline to CL training

Must rethink process for how people get selected for leadership roles. It feels purely like a popularity contest and contributions to the organization seem to matter very little. There is also very little investment in mentoring people in smaller leadership roles to take on larger leadership roles and minimal transparency about any of these processes.

Lack of diversity in Board membership and leadership.

URGING MORE ATTENTION TO DISABILITY/SPECIAL NEEDS

I am not sure that disabilities as an entity have been focused on, specifically disabilities in psychiatrists, trainees, etc. and how to address those better.

Focusing on the lived experience of people with disabilities including families and individuals with intellectual disabilities. Many physicians are extremely ableist towards people with intellectual disabilities and this is a major blind spot.

There may be a place for more programming related to special care needs or psychoeducation for practitioners with diverse populations

Think about hidden disabilities

Needs far more content on accessibility in CL psychiatry. More representation of patient voice. Needs of young adults with autism, speech, language or other communication disorders that impact emotion regulation and coping with illness, sensory issues including those affecting food intake and nutrition

More on disability

Invite speakers from the world of disability, especially intellectual disability advocacy.

I think that viewpoints from the disability perspective may be under-represented.

More members living with a disability in leadership roles and organizing committee work

It may be helpful to partner with the national physiatry organization to better understand and organize educational needs around disability healthcare inequities.

I think it is easy to focus on race and sexual identity issues but not recognize that diversity includes many other things besides this. For example, inclusion of people with Down syndrome or other cognitive issues is something that is seldom discussed.

There is a highlight on physical disability but it seems to miss neurodiversity like ADHD, autism, etc. I do wonder about that in general.

URGING INCREASED ATTENTION TO ADVANCED PRACTICE PROVIDERS

There is a huge emphasis on physicians but NP's are servicing as provider the population in large numbers.

Please label NPs online and on surveys as "Nurse Practitioner" rather than nurse or advanced practice RN or Advanced practice nurse. The public recognizes nurse as RN and Nurse Practitioner as Clinician and Provider. It's important to differentiate Nurse Practitioner from Nurse.

Be more welcoming to Advanced Practice Clinicians (PAs and NPs) -- having a name tag color/badge for APCs, fosters leadership of PAs/NPs (currently the APC specific workshops are still led by MDs)

Be more inclusive with nurse practitioners/PA's

Increasing presence of APPs