

**Title: Psychiatry Diversity Leadership in Academic Medicine: Guidelines for Success**

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# MANUSCRIPT

## Case Presentation

Dr. Pierce, a Black woman researcher and clinician-educator in the Department of Psychiatry at a prestigious academic institution was appointed Chair of the Diversity, Equity, and Inclusion (DEI) committee in 2017, in the context of public complaints and media coverage concerning sexism and racism. Following recent high-profile murders of Black people by police, Dr. Pierce is called upon by the department chair to develop “anti-racist programming.” As a first step, Dr. Pierce drafts a strong message against racism and excessive police force. Despite the statement being vetted by all senior leadership, the department chair insists that Dr. Pierce place only her name on the response, in case it is not “*well received.*” Dr. Pierce receives negative emails in response to the statement, with minimal support from the department. Not to be dismayed, Dr. Pierce assembles a DEI committee to plan an “anti-racist” strategy for the entire department, without financial support, protected time, or additional resources. The DEI committee progress is slowed by the lack of institutional and departmental commitment. Additionally, several well-meaning non-Black colleagues in the department organize responses to the murders—including protests, town hall events, and public statements—without concerted coordination with the DEI committee, implying that “*nothing was being done.*” In parallel, Dr. Pierce is tasked with organizing and dispatching the limited number of Black psychiatrists, psychologists, and social workers in the department to deliver care to the entire Black community at her institution.

Feeling overwhelmed by the number of tasks she has been asked to initiate, while navigating a tense climate, with minimal financial or administrative departmental support—Dr. Pierce requests a meeting with the department chair and executive committee. At the meeting, Dr. Pierce, a tenured faculty member for the past ten years, is addressed by another colleague’s name—the only other Black professor in the department. When Dr. Pierce points out this microaggression, a senior colleague tells her she is being “too sensitive,” and is “overreacting.”

Despite this interaction, Dr. Pierce highlights multiple institutional barriers, including the structural racism that minimizes the work of DEI initiatives in the department. She presents her proposal for protected time and resources to successfully execute robust anti-racist programming, but is told money is tight and to “scale back,” and “do the best you can.”

### **Importance of DEI Leadership**

As DEI leaders at major academic psychiatry programs across the US, we recognize the importance of these positions and advocate for increased support for our activities. Diversity improves productivity, supports recruitment and retention, fosters enhanced innovation, and promotes a more inclusive workforce climate [1]. International protests centering the Black Lives Matter (BLM) movement—triggered by the recent murders of Ahmaud Arbery, Breonna Taylor, and George Floyd, underscored by a COVID-19 pandemic with racial inequities in morbidity and mortality—have resulted in an urgent need for psychiatry departments to reexamine and commit to fully supporting these leadership positions.

Unfortunately, the case of Dr. Pierce is not unique. DEI leadership roles are typically held by women and/or Black, Indigenous, Persons of Color (BIPOC) with limited resources, such as lack of salary support, discretionary funds, or administrative backing [2, 3]. As our nation publicly confronts the ongoing trauma of systemic racism, academic institutions are being called to critically evaluate and interface with racism in new ways. DEI leaders are being summoned for one-on-one and programmatic consultation, anti-racist curriculum development, anti-bias training, and skill acquisition. However, many of these institutions do not provide the appropriate resources or support necessary to institute an effective response for cultural change [4]. This lack of scaffolding leads to an exacerbation of the “minority tax,” thereby placing more duress on the very same people adversely affected by structural racism. As a result, many in DEI leadership positions have become frustrated and disillusioned with the lack of commitment—leading many to leave academia and organized medicine [4-6].

Academic psychiatry must acknowledge the role that our field has played in creating and perpetuating racist structures and ideas. From this place of recognition, DEI leaders are uniquely poised to use their expertise in understanding attitudes, emotions, behavioral changes, and trauma in order to move toward reconciliation. Implementing strategic decisions related to anti-racism and DEI is critically important to promote academic excellence in research, clinical care, and education. Patients, medical students and residents, physicians, and scientists who identify as BIPOC are struggling with the weight of racism and inequity. DEI leaders are critical in guiding departments and institutions across the country to develop structural changes to promote resilience. Below, we outline the current landscape of DEI leadership within psychiatry at academic medical centers and share our vision for how this important role should be structured and compensated.

### **Current Landscape of Diversity Leaders**

We represent DEI leaders at public and private psychiatry departments across the country. Our departments include seven of the Top 10 Psychiatry Departments, according to the 2020 *U.S. News & World Report* rankings [7]. In our small sample (N=9), 100% are women, and 89% are BIPOC. The mean age is 46 (range 40-51), 77% are mothers and 44% are informal caregivers of seriously ill family members. Over half of the leaders are either the primary breadwinner of their family and/or provide financial support to extended family. The majority of leaders are psychiatrists, with one psychologist in the sample. There was a range in academic rank: two Assistant Professors, four Associate Professors, and three full Professors.

We found a wide range of DEI titles, falling into three categories: Vice or Associate Chairs (33%), Directors (22%), and Diversity Ambassadors/Members or Chairs of Diversity Committees (44%). Slightly more than half (56%) of these leaders sit on departmental executive committees. Only one leader holds a named endowed chair, while 44% received no compensation or salary support for these roles. For those DEI leaders who do receive salary support, the average compensation is \$48,000 (range: \$10,000-\$100,000), representing approximately 18% (range 5-36%) of their total

salary. This is lower than the estimated average effort these leaders report investing in these roles (23%, range 10-30%). Unpaid leaders estimate spending 16% effort on DEI activities (range 10-30%). Only 33% of the leaders are provided with support staff (e.g., an administrative assistant), at 25% effort (range 5-50%). Approximately 55% received some discretionary support (average \$27,800, range \$2,000-\$100,000), and only two of those five have these funds renewed annually.

### **Challenges of Limited Representation of Women and BIPOC Faculty in Leadership Positions**

DEI roles are challenging for several reasons. Leadership hurdles are often higher for BIPOC women than white men and women, leading to attrition with limited representation [8-10]. BIPOC women face additional challenges due to the influence of race and ethnicity on perceptions of leadership [11]. BIPOC women experience issues of intersectionality, meaning that they must disentangle whether to attribute workplace discrimination to gender, race, or other aspects of their identity (e.g., disability, sexual orientation) [12].

*Leadership Hurdles and Lack of Representation:* BIPOC psychiatry faculty typically endure discrimination and lack peers who look like them to provide support. In 2019, inequities in retention and promotion of psychiatric faculty at US medical schools were prominent. White male psychiatrists were promoted to full professor rank at a full-professor-to-assistant-professor ratio of 0.74 [13]. For white women, the ratio lagged far behind at 0.26, similar to Black men at 0.24. For BIPOC women, the full-professor-to-assistant-professor ratio was 0.14, and concerningly, the ratio for Black women was 0.08. A similar imbalance is seen at the highest levels of leadership, with white males comprising 61% of psychiatry department chairs compared to white women (17%), Latinx men (3.9%), Latinx women and Black women (both 1.9%), and Black men (0.6%). Finally, there is an absence of mentors and sponsors that can identify meaningful roles and advise DEI leaders on how to reduce less rewarding tasks and successfully advance in academia. Frequently, their work is devalued, which contributes to isolation and burnout [14].

Minority Tax: Due to the limited numbers of BIPOC women in psychiatry faculty positions, many DEI leaders face isolation, excessive time burdens, and additional “taxes” on their time. This double minority tax (gender and racial and ethnic underrepresentation in medicine) limits their ability to be effective [2]. In order to demonstrate institutional diversity, BIPOC faculty are frequently asked to serve on committees, liaise with community groups, and mentor students, but such work is not compensated or part of promotional activities [15]. DEI leaders are also often asked to oversee cultural humility and anti-racism courses and serve as “supermentors” of trainees; uncompensated. This results in unique harms, including decreased pay, uncompensated labor, and scholarship that is not recognized/devalued, resulting in moral injury.

Family Caregiving Responsibilities: A large proportion of our DEI leader sample are also mothers, informal caregivers, and/or provide financial support to extended family members [common for BIPOC women earners [16]], exemplifying both the vulnerability—and resilience—of these leaders. Studies have shown that physician mothers experience discrimination at work and are at risk for burnout and mental health issues [4, 8].

### **Essential Community Support Needed for DEI Leadership**

To consider next steps in alleviating the challenges facing BIPOC women in DEI positions within psychiatry, a small group of DEI leaders convened at the Annual Meeting of the American Psychiatric Association (APA) in San Francisco in May 2019. DEI leaders shared common concerns and challenges. The group agreed to meet regularly for support, scholarship, and to promote equity in academic medicine. This group not only provides a space for sharing lived experience, but also offers a respite for the trauma endured by oppressive structures within academic psychiatry. The space is liberating in that it allows BIPOC DEI leaders to speak openly about hurtful, discriminatory experiences without a sense of “careful wording” that is required in other settings. In short, this is a place for disagreement, tears, support, and processing of racist experiences.

Additionally, this group provides critical peer mentorship through the sharing of differing institutional cultures and the ingredients for success and pitfalls in leading diversity efforts. Due to limited numbers of BIPOC women in senior faculty, finding mentors can be challenging. Peer support and mentorship is a critical ingredient to success. In addition to mentorship, these communities provide an “old girls” network, which can lead to an increase in sponsorship and opportunities.

### **Supporting BIPOC Women in DEI Leadership in the Face of Two Pandemics**

As our nation faces two national pandemics—COVID-19 and racism—we believe this is the ideal time to reenvision DEI leadership positions in psychiatry. During the COVID-19 pandemic, women are at risk for psychological impacts, and early evidence shows productivity decline among women in academia [17-19]. The financial toll of the COVID-19 pandemic has also resulted in heightened stress for many DEI leaders who are the primary breadwinners in their household. Although the increased attention upon structural racism is an outstanding step forward for our country to reckon with, the case exemplifies the rush to quickly address long-standing inequities due to racism, with departments hastily creating DEI positions only to check a box as having “done something” [4]. Such performative responses may set up new DEI leaders for failure, and therefore provide later fodder for claiming that DEI efforts were not effective. Further, research shows that leaders point to the existence of DEI structures as proof that there is equity and fairness, while ignoring information about continued discrimination—despite the burden/responsibility of addressing structural racism needing to fall primarily to White people who hold institutional power [15].

As DEI leaders at major psychiatry departments across the US, we have thrived in academia, not despite, but *because* we are BIPOC women, mothers, informal caregivers, and breadwinners. In this piece we intentionally highlighted the intersectional experiences of women in diversity roles. In addition to being from two historically excluded groups (gender and racial/ethnic minorities), many of these leaders hold responsibilities in our households that impact their leadership roles. This focus



was necessary, given how little emphasis is placed on the experience of women in leadership roles, especially those from racial/ethnic minority backgrounds. We do think however, that understanding the male perspective is an area worth pursuing in the future, as data on these experiences will likely provide a valuable comparison.

In conclusion, DEI efforts should not be isolated from the power structures within a department, but instead integrated into the highest levels of decision-making to ensure a presence and active voice in any setting where real power is wielded. Table 1 provides recommendations for the necessary support for the success of DEI leadership. Only through adequate financial, administrative, and structural support can inclusive excellence begin to be infused into all departmental activities.

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## TABLES/FIGURES

**Table 1: Best Practices to Effectively Support Psychiatry DEI Leadership Efforts**

### Structural Changes to Recognize DEI Commitment

- **Title**: Vice or Associate Chair in the Department, a strategic elevation of the role to clearly state the importance of the role.
- **Leadership Team**: Departmental cabinet and/or executive committee membership
- **Endowed Chair**: Strongly consider a named endowed chair to afford academic prestige and financial support/stability that the position deserves.

### Financial Support

- **Salary Support**: This is critical, with an ideal range of 25-100%, reflective of effort, with very explicit management of expectations given effort. Funding via a named endowed chair would ensure stability of support.
- **Discretionary Funds**: This leader will require discretionary support for implementation of policies, at least \$50,000, renewed annually.
- **Staff**: A full-time administrative assistant and/or program manager is critical for this role. In addition, we recommend at least 10% time for a data analyst, as structural accountability requires data management and infrastructure.

### The Role

- **Job Description**: The roles and responsibilities of the DEI position should be clear when the position is first presented to potential candidates, with responsibilities commensurate with financial effort provided.
- **Reporting Structure**: Dual reporting to both the department chair and School of Medicine's Dean's Office (or hospital/institution) DEI leader.

- **Diversity Committee**: Create a diversity committee, led by the DEI leader, that includes members that represent missions across the Department. These members should ideally be diverse in terms of race/ethnicity, gender identity, sexual orientation, site, and role (faculty, trainee, staff). This committee will implement the majority of the work under the vision of the DEI leader.

- **Selection**: The selection should follow current departmental process for all Vice Chairs at the institution [which should be an internal (or external) searched position with a search committee reflective of the diversity of the Department]. Selection of leader should not be held to higher standards than other Vice Chairs.

- **Professional Development**: The DEI leadership position is complex and requires leadership skills training. As such, the discretionary funds should be allowed to be used for professional development activities for the DEI leader.

- **Evaluation**: As with all leaders, we recommend term limits for this role [20]. We recommend evaluation at 5 years, with a 10-year maximum term. Evaluation of the leader should follow the current departmental processes for all other Vice Chairs at the institution.

### **Overall Considerations**

- All DEI decisions, actions, and statements should come jointly from the department chair and DEI leader (and ideally the entire executive committee leadership), to avoid scapegoating and to ensure accountability of the entire leadership team.
- Inclusive excellence should be part of the breath and heartbeat of the entire department. It should be woven throughout the clinical, research, and educational missions.

- **DEI leaders thrive with peer communities. Chairs should intentionally connect their DEI leaders to University and national DEI communities for support and sharing best practices**