Occupational Therapy's Commitment to Diversity, Equity, and Inclusion

The American Occupational Therapy Association's (AOTA's) *Vision 2025* conveys a strong commitment to diversity, equity, and inclusion (AOTA, 2019). AOTA affirms the inalienable right of every individual to feel welcomed, valued, a sense of belonging, and respected while accessing and participating in society, regardless of the internal or external factors that make every individual unique. This statement supports efforts to increase diversity, equity, and inclusion within all aspects of occupational therapy, including practice, education, and research, as well as policy development and advocacy.

Definitions

Diversity is broadly defined as the unique attributes, values, and beliefs that make up an individual (Taff & Blash, 2017) when compared with the context of a group or population. Diversity comes in many forms, including, but not limited to, socioeconomic status, race, sex, ethnicity, age, disability, sexual orientation, gender identity, and religious beliefs. Although diversity of thought and preferences does exist in the presence of homogenized groups, diversity of thought is often magnified with increased diversity of individuals making up a group. Increased diversity of staff has been linked to increased creativity and efficiency in the workplace (Hall et al., 2011).

Nondiscrimination exists when all people are treated equitably. In doing so, differentiating between people because of biases or prejudices can be avoided. Individuals should be valued, and their various forms of diversity should be respected and valued in line with the principles defined and described in the *Occupational Therapy Code of Ethics* (AOTA, 2015). Nondiscrimination is a necessary prerequisite for inclusion (AOTA, 2014).

Equity describes an approach that ensures everyone has access to the same opportunities, taking into consideration the advantages and disadvantages of every individual (World Health Organization [WHO], 2019). Equity is often confused with equality; however, they are significantly different. Equality ensures that everyone receives the same benefit or consequence. Equity recognizes that advantages and barriers exist due to diversity and social conditions. As a result, not everyone is afforded the same initial opportunities to participate in society. Equity acknowledges the unequal "starting place" between members in society and strives to correct the imbalance.

Inclusion is the acceptance and support of diversity wherein the uniqueness of beliefs, values, and attributes is welcomed, valued, and leveraged for maximum engagement (Taff & Blash, 2017). Inclusion is not simply tolerance. *Tolerance* is not acceptance, but rather denotes recognition that something must be allowed to occur regardless of personal preference. Inclusion inherently

The American Journal of Occupational Therapy, November/December 2020, Vol. 74, Suppl. 3 7413410030p1

embraces the value of all individuals. Whereas diversity pertains to the internal and external factors that make an individual unique, inclusion is the active response to diversity—fostering acceptance, respect, belonging, and value for each individual. To support diversity, inclusion must be actively pursued.

The occupational therapy community, which includes practitioners, students, researchers, and educators, recognizes that policies based on health equity play a central role in health outcomes. *Health equity* occurs when everyone has the opportunity to be as healthy as possible, regardless of their social position or other socially determined circumstances (Centers for Disease Control and Prevention [CDC], 2019). Health equity approaches are necessary to mitigate against health disparities. The U.S. Medicaid system is an example of such an approach in which individuals and families with low income are assisted with reimbursement for health care to decrease disparities (Medicaid, 2019). AOTA supports, values, and respects diversity and calls for fair and equitable treatment of all, regardless of an individual's attributes, beliefs, and values (AOTA, 2015).

History, Ethics, and Values

The preamble of the AOTA (2015) *Occupational Therapy Code of Ethics* states that practitioners "are committed to promoting inclusion, participation, safety, and well-being for all recipients . . . and to empowering all beneficiaries of service to meet their occupational needs" (p. 1). Occupational therapy has a long history of focusing on the needs of the individual within the various contexts in which the individual engages in occupations. This idea is rooted in pragmatism, a foundational philosophy of occupational therapy. *Pragmatism* is based on "the growth of knowledge through change and adaptation" (Breines, 1987, p. 523).

Congruent with the historical application of pragmatism is the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2020), which describes the importance of contexts as interrelated variables that influence participation. The relevance of political or institutional contexts has far-reaching implications for all individuals, especially marginalized groups who are not afforded the same rights and access to resources as the majority of society. In turn, these factors can significantly affect occupational opportunities and result in occupational injustice. The occupational therapy profession has a vested interest in addressing occupational injustice (Braveman & Bass-Haugen, 2009). *Occupational justice* refers to the right of all individuals to participate and have equity in occupational choice to increase their well-being (Hocking, 2017).

Supportive or even enriched contexts are necessary for health, well-being, and participation and provide increased opportunity for occupational pursuits. To meet the needs of marginalized populations, the occupational therapy community must "seek to understand and address how occupations are shaped by broader social and structural determinants" (Gerlach, 2015, p. 248) through a new, critically informed approach. To be critically informed, occupational therapy practitioners must attend to the "interaction of sociocultural characteristics, such as gender, ethnicity, age, geography, and so forth, as they intersect with adverse social determinants that stem from broader structural factors" (Gerlach, 2015, p. 249).

Cultural competence was a widely accepted term used in occupational therapy to describe the ability to understand and effectively interact with people of all cultures. However, use of this term proved problematic in that no one really can assume competence with regard to culture, which is rich in variability and complexity. In the past two decades, the term *cultural competence* has gradually been replaced with *cultural relevance, cultural sensitivity,* and other similar terms. At the core of these terms are the concepts that form cultural humility, which is a more viable way to frame how the occupational therapy community should approach challenges related to addressing the needs of a diverse population.

Cultural humility is an approach that emphasizes humble and empathetic communication with clients, with reduced reliance on bias or implicit assumptions (Beagan, 2015). This approach dispels the myth that individuals in the occupational therapy community might be able to learn everything there is to know about cultures other than their own simply through emphasizing

The American Journal of Occupational Therapy, November/December 2020, Vol. 74, Suppl. 3 7413410030p2

differences. Cultural humility instead emphasizes "attentive listening and openness to other cultures, and [it] stress[es] the importance of self-reflection and self-critique in our interactions with others" (Isaacson, 2014, p. 251). It is important for members of the occupational therapy community to be prepared to serve diverse populations through the lens of cultural humility. Working with clients through the lens of cultural humility encourages an openness to learn from others instead of trying to memorize certain cultural ideas and concepts in trying to achieve a level of competence.

Occupational therapy practitioners strive to treat all people impartially, reduce bias, create diverse communities in which members can flourish and function, address conditions that hinder or cause harm to others, and protect and defend the rights of individuals (Beauchamp & Childress, 2013). In the United States, the profession of occupational therapy is grounded in seven Core Values that include Equality and Justice (AOTA, 2015). The AOTA (2015) Code of Ethics states that practitioners should "advocate for changes to systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy services" (p. 5).

Implications for Occupational Therapy Practice, Education, Research, and Policy Development

With increased diversity comes opportunities for increased cultural differences, more diverse languages spoken, and more varied forms of occupational participation—to name a few. Racial and ethnic minorities make up 38.1% of the population in the United States (U.S. Census Bureau, 2016), and this number is projected to grow to 52% by 2055 (Pew Research Center, 2015). Approximately 10 million adults, or 4.1% of the U.S. population, identify as belonging to the LGBT[1] community, with that self-report statistic rising over the past five years and anticipated to continue to rise (Pew Research Center, 2017). The U.S. Census Bureau (2018) reported that 85.3 million Americans, or 27.2%, live with a disability. In respect to these data, it is imperative to recognize and understand the concept of intersectionality (Crenshaw, 1989), because multiple forms of discrimination such as racism, classism, ableism, transphobia, homophobia, and sexism may intersect and affect individuals who identify as part of multiple marginalized groups.

Health disparities and inequalities exist across a wide range of diverse groups. Research on factors such as the environment, social determinants, and health care access has documented disparities among diverse populations (CDC, 2013; Downing & Przedworski, 2018; Peterson et al., 2018; Saha et al., 2008). National data have also demonstrated that distinct differences exist in health, social, and behavioral characteristics; activity profiles; home and work environments; engagement with health care systems; and health outcomes among different racial and ethnic groups and income levels, and these differences are significant for future occupational therapy research, education, and practice (Bass-Haugen, 2009). For instance, the CDC found higher tobacco use among certain ethnic groups, LGBT[1] populations, and individuals with mental health conditions (CDC, 2015). Further occupational therapy research into these types of occupational behaviors within marginalized groups may help guide future practice, education, research, and public policy development.

The occupational therapy community does not reflect the current or projected population of the United States, which may increase the profession's "blind spots" as practice, education, research, and policies advance. To be an inclusive profession, there must be diverse representation. Many members of the occupational therapy community from underrepresented groups may face or be affected by the same discrimination as the clients they serve. Being able to identify with this lived experience may help shape the services they provide to diverse individuals. As the population of the United States becomes more diverse, the profession of occupational therapy must strive to meet the ever-changing occupational needs of society's diverse populations.

[1]Although LGBT is used in this source, the more inclusive and preferred term is *LGBTQ+,* which is used to represent the large and diverse communities of individuals with nonmajority sexual orientations and gender identities.

Reshaping the profession to reflect the demographics of the United States can more effectively reduce health disparities and provide better and more equitable outcomes for all individuals served. Diverse professionals are more likely to stay in underrepresented communities longer, thus providing more effective occupational therapy services to their clients (Gerlach, 2015). Equity and inclusion initiatives, as well as initiatives to improve diversity in the workforce, are needed now more than ever to strengthen the occupational therapy profession.

Academic programs must consider integration of intentional strategies to promote diversity, equity, and inclusion throughout all phases of the academic continuum, including student recruitment, student admissions, teaching of content and coursework, curriculum design, and assessment (U.S. Department of Health and Human Services, 2013). Academic programs serve as gatekeepers to the profession and must commit to preparing a workforce that is adequately prepared to meet the diverse needs of society. Multipronged and deliberate approaches are required to attract students from underrepresented groups and to achieve success in meeting diversity goals (Cahn, 2015).

Recruitment of occupational therapy students at historically black colleges and universities as well as recruitment of members of nonmajority religious groups or other underrepresented groups in academia can help facilitate these efforts. Creating diversity pipeline programs in education that target underrepresented groups can help shape the occupational therapy community to more closely reflect the demographics of our country (Bouye et al., 2016). A diverse occupational therapy community can leverage its distinct interests by increasing research in underexplored areas, increasing awareness of occupational therapy services among underrepresented groups, and recruiting future members of underrepresented groups, all of which are areas that can also shape potential future public policies.

Research initiatives for both improved health and educational outcomes should be intentional in addressing diverse societal needs, including disparities in health care access, equitable services, and workforce needs for underrepresented communities (Cahn, 2015). Entities such as the National Institutes of Health (2019) have implemented safeguards to promote health equity and now mandate the inclusion of women and minority groups in clinical research as appropriate to scientific questions being investigated. It is imperative that health equity is addressed in occupational therapy research, practice, and public policy development.

Conclusion

Occupational therapy is at the forefront of developing and providing client-centered services that improve community participation, reduce hospital readmission (Rogers et al., 2017), increase engagement in meaningful occupations, and allow individuals to live life to the fullest (AOTA, 2019). To meet the needs of diverse communities, it is essential that the occupational therapy community embrace cultural humility. Increased awareness about one's self, one's own personal biases, and others can empower practitioners, organizations, and health care systems to create policy and programs that provide more equitable care that maximizes the health potential and quality of life for all people. As such, welcoming and inclusive environments must be incorporated as a quality indicator for all aspects of occupational therapy, including practice, education, and research.

Occupational therapy's client-centered approaches distinctly focus on facilitating participation in meaningful occupations, and this outcome would not be possible without a commitment to diversity, equity, and inclusion. The profession of occupational therapy is resolute in its commitment to diversity, equity, and inclusion for its student bodies, workforce, and client populations and to advocacy for policies that lead to stronger, healthier, and more engaged communities.

To fulfill this commitment, practitioners must facilitate interprofessional dialogue and engage communities through the intentional development of ongoing educational initiatives related to diversity, equity, and inclusion. Underrepresentation in the workforce must be actively addressed through the development of accessible pathways and resources to support students and practitioners in occupational therapy. In addition, occupational

The American Journal of Occupational Therapy, November/December 2020, Vol. 74, Suppl. 3 7413410030p4

therapy educational curricula must adequately prepare students for serving diverse populations through a lens of cultural humility. Occupational therapy practitioners must commit to addressing challenges through evidence-based solutions to promote growth and development of the profession of occupational therapy. As such, occupational therapy is poised to lead in diversity, equity, and inclusion to maximize the health, well-being, and participation of all people, groups, and populations.

References

American Occupational Therapy Association. (n.d.). *Consider becoming an occupational therapist*. https://www.aota.org/Education-Careers/Considering-OT-Career/Resources/consider-becoming-ot.aspx

American Occupational Therapy Association. (2014). Occupational therapy's commitment to nondiscrimination and inclusion. *American Journal of Occupational Therapy*, *68*(Suppl. 3), S23–S24. https://doi.org/10.5014/ajot.2014.686S05

American Occupational Therapy Association. (2015). Occupational therapy code of ethics (2015). *American Journal of Occupational Therapy*, *69*(Suppl. 3), 6913410030. https://doi.org/10.5014/ajot.2015.696S03

American Occupational Therapy Association. (2019). The Association—AOTA board expands *Vision 2025*. *American Journal of Occupational Therapy*, *73*, 7303420010. https://doi.org/10.5014/ajot.2019.733002

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy*, *74*(Suppl. 2), 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

Bass-Haugen, J. D. (2009). Health disparities: Examination of evidence relevant for occupational therapy. *American Journal of Occupational Therapy*, *63*, 24–34. https://doi.org/10.5014/ajot.63.1.24

Beagan, B. L. (2015). Approaches to culture and diversity: A critical synthesis of occupational therapy literature. *Canadian Journal of Occupational Therapy*, *82*, 272–282. https://doi.org/10.1177/0008417414567530

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Bouye, K. E., McCleary, K. J., & Williams, K. B. (2016). Increasing diversity in the health professions: Reflections on student pipeline programs. *Journal of Healthcare, Science and the Humanities*, *6*, 67–79.

Braveman, B., & Bass-Haugen, J. D. (2009). Social justice and health disparities: An evolving discourse in occupational therapy research and intervention. *American Journal of Occupational Therapy*, *63*, 7–12. https://doi.org/10.5014/ajot.63.1.7

Breines, E. (1987). Pragmatism as a foundation for occupational therapy curricula. *American Journal of Occupational Therapy*, *41*, 522–525. https://doi.org/10.5014/ajot.41.8.522

Cahn, P. S. (2015). Do health professions graduate programs increase diversity by not requiring the Graduate Record Examination for admission? *Journal of Allied Health*, *44*, 51–56.

Centers for Disease Control and Prevention. (2013). *CDC health disparities and inequalities report*. https://www.cdc.gov/minorityhealth/chdireport.html

Centers for Disease Control and Prevention. (2015). *Best practices user guide: Health equity in tobacco prevention and control*. https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

Centers for Disease Control and Prevention. (2019). *Health equity*. https://www.cdc.gov/healthequity/index.html

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum, 1989*, 8. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/

Downing, J. M., & Przedworski, J. M. (2018). Health of transgender adults in the U.S., 2014–2015. *American Journal of Preventive Medicine*, *55*, 336–344. https://doi.org/10.1016/j.amepre.2018.04.045

Gerlach, A. J. (2015). Sharpening our critical edge: Occupational therapy in the context of marginalized populations. *Canadian Journal of Occupational Therapy*, *82*, 245–253. https://doi.org/10.1177/0008417415571730

Hall, G. C. N., Martinez, C. R., Jr., Tuan, M., McMahon, T. R., & Chain, J. (2011). Toward ethnocultural diversification of higher education. *Cultural Diversity and Ethnic Minority Psychology*, *17*, 243–251. https://doi.org/10.1037/a0024036

Hocking, C. (2017). Occupational justice as social justice: The moral claim for inclusion. *Journal of Occupational Science*, *24*, 29–42. https://doi.org/10.1080/14427591.2017.1294016

Isaacson, M. (2014). Clarifying concepts: Cultural humility or competency. *Journal of Professional Nursing*, *30*, 251–258. https://doi.org/10.1016/j.profnurs.2013.09.011

Medicaid. (2019). *About us*. https://www.medicaid.gov/about-us/index.html

National Institutes of Health. (2019). *Inclusion of women and minorities as participants in research involving human subjects*. https://grants.nih.gov/grants/funding/women_min/women_min.htm

Peterson, K., Anderson, J., Boundy, E., Ferguson, L., McCleery, E., & Waldrip, K. (2018). Mortality disparities in racial/ethnic minority groups in the Veterans Health Administration: An evidence review and map. *American Journal of Public Health*, *108*, e1–e11. https://doi.org/10.2105/AJPH.2017.304246

Pew Research Center. (2015). *By 2055, the U.S. will have no racial or ethnic majority group*. https://www.pewhispanic.org/2015/09/28/modern-immigration-wave-brings-59-million-to-u-s-driving-population-growth-and-change-through-2065/ph_2015-09-28_immigration-through-2065-17/

Pew Research Center. (2017). *5 key findings about LBGT Americans*. https://www.pewresearch.org/fact-tank/2017/06/13/5-key-findings-about-lgbt-americans/

Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2017). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review*, *74*, 668–686. https://doi.org/10.1177/1077558716666981

Saha, S., Freeman, M., Toure, J., Tippens, K. M., Weeks, C., & Ibrahim, S. (2008). Racial and ethnic disparities in the VA health care system: A systematic review. *Journal of General Internal Medicine*, *23*, 654–671. https://doi.org/10.1007/s11606-008-0521-4

Taff, S. D., & Blash, D. (2017). Diversity and inclusion in occupational therapy: Where we are, where we must go. *Occupational Therapy in Health Care*, *31*, 72–83. https://doi.org/10.1080/07380577.2016.1270479

U.S. Census Bureau. (2016). *Quick facts—United States*. https://www.census.gov/quickfacts/fact/table/US/RHI125216

U.S. Census Bureau. (2018). *Americans With Disabilities: 2014*. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice*. https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

World Health Organization. (2019). *Health equity*. https://www.who.int/topics/health_equity/en/

Authors

Stacy Wilson, MS, OTR/L
Cristina Reyes Smith, OTD, OTR/L
Cheranne Hunter-Bennett, MS, OTR/L
Catherine R. Hoyt, PhD, OTD, OTR/L

for

The Commission on Practice

Julie Dorsey, OTD, OTR/L, CEAS, FAOTA, *Chairperson*

and

The Commission on Education

Tina DeAngelis, EdD, OTR/L, *Chairperson*

Adopted by the Representative Assembly, May 2020

Note. This document replaces the 2014 document *Occupational Therapy's Commitment to Nondiscrimination and Inclusion,* previously published and copyrighted by the American Occupational Therapy Association in the *American Journal of Occupational Therapy, 68*(Suppl. 3), S23–S24. https://doi.org/10.5014/ajot.2014.686S05

Citation. American Occupational Therapy Association. (2020). Occupational therapy's commitment to diversity, equity, and inclusion. *American Journal of Occupational Therapy, 74*(Suppl. 3), 7413410030. https://doi.org/10.5014/ajot.2020.74S3002