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Diversity and Inclusion in Occupational Therapy: Where We Are, Where We Must Go

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ABSTRACT

Diversity is a fundamental element of the AOTA *Centennial Vision* and a critical aspect for the visibility, growth, and sustainability of the occupational therapy profession. In this article, the authors suggest that, while the profession has been aware of the need for a diverse workforce and has taken steps to increase diversity and cultural competency, a more structured, comprehensive, and action-oriented approach must be considered to address an issue which impacts professional roles and client engagement, satisfaction, and well-being. Informed by the value-added and mutual accommodation models of cultural diversity, the authors provide specific strategies and actions which promote diversity and inclusion at the personal, institutional/organizational, and professional levels.

Introduction

The American Occupational Therapy Association (AOTA) *Centennial Vision* states that "We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally-connected and diverse workforce meeting society's occupational needs" (American Occupational Therapy Association [AOTA], 2007). Diversity and inclusion are not simply elements of a greater professional vision; they are also antecedents for supporting occupational therapy's growth and visibility internationally. This is echoed in *Vision 2025*, which conceptually builds upon the *Centennial Vision*: "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (AOTA, 2016). *Vision 2025* addresses the larger social context in which diversity and inclusion are paramount, namely within community and population health.

Conversations regarding diversity are not new to occupational therapy (Grady, 1995; Black, 2002; Abreu & Peloquin, 2004; Clark, 2013). However, these conversations need enhanced translation into action plans to build and support a more diverse workforce. The broad aim of this paper is to explore the issue of diversity

and inclusion in occupational therapy and offer strategies necessary to achieve the goal of building a diverse workforce in the profession. Throughout the paper, we reiterate the need for occupational therapy to recognize diversity and inclusion as concepts having significant implications for the sustainability and prominence of the profession. Diversity and inclusion have often been cast in an ethical light and focused on the individual client encounter, but less frequently in an applied, professionally centered manner. In order to achieve a more diverse workforce, the profession needs to create and support institutionally accepted systems which promote diversity and inclusion along a continuum from student recruiting to organizational re-structuring. We set out to accomplish our objectives by first framing the issue, which includes defining what we mean when we discuss "diversity" and "inclusion" and providing a reminder of why diversity and inclusion are so very crucial to the livelihood of the profession. We follow this with a brief synopsis on the current state of diversity and inclusion in Occupational Therapy- "where we are" in terms of creating a diverse workforce. Next, we briefly describe four models of diversity which are commonly found in organizations and institutions. We then conclude with examples and a case study which utilize the value-added and mutual accommodation models of diversity to guide practical ideas for implementing change in occupational therapy at the person, program/institutional, and professional levels—"where we must go".

Diversity and inclusion defined

The term "diversity" has been historically operationalized in myriad ways, frequently in reference to methods of erasing discrimination in organizations and institutions. In the context of higher education, it has also been synonymous with overall student body composition (Milem, Chang, & Antonio, 2005). However, for the purposes of this paper and subsequent strategies, we suggest these somewhat limited conceptions of the term are inadequate. Ross (2011) provides more breadth, using the term diversity to describe "the broad field of issues related to difference …as well as issues relating to how people of different kinds are participating in a particular organization or society" (p.37). The spirit of the present discussion aligns more congruently with The American Association of Colleges and Universities (AAC& U) report, *Making Diversity Work on Campus* (Milem, Chang, & Antonio, 2005) definition of diversity as "engagement across racial and ethnic lines comprised of a broad and varied set of activities and initiatives" (p. 4).

Society is increasingly viewing diversity from a wider perspective, which now includes gender, disability, religious beliefs, and sexual orientation in addition to race and ethnicity. In occupational therapy practice, all aspects of diversity can impact the quality and outcome of services, while certain ones will be more critical depending upon each unique context. While fully supporting the need to approach diversity with a wide lens, in this paper we narrow our focus to race, as race is a category that historically has significantly impacted social status (Goffman, 1959; Rajaman & Bockrath, 2014). Other studies have supported this assertion, indicating

that racial interactions have more impact than non-racial interactions (Bowman, 2010). Despite our focus on race as a factor, other social identities and related factors (such as language) can easily be addressed within the actions we suggest.

Inclusion is a related concept, one that has received neither the media nor the scholarly attention that has accompanied diversity. Inclusion can be thought of as fostering an environment where uniqueness of beliefs, backgrounds, talents, capabilities, and ways of living are welcomed and leveraged for maximum engagement (including decision-making) by members of the learning or working community (Bleich, MacWilliams, & Schmidt, 2015). It is paramount that efforts to include all people are encouraged by senior leaders, on-going and intentional. Ross (2011) views inclusion as a "function of how fully involved people are in the structures of their organizations …Inclusion is a function of connection" (p. 38). Adding dimensions of diversity- simply having a presence- is not enough. People must feel as if they have opportunities for meaningful and sincere connections with others which allow them to be valued members of their communities (Milem, Chang, & Antonio, 2005; Museus, 2014). Inclusion does not occur automatically via proximity. It must be built, nurtured and sustained as part of organizational or professional culture. To persist and succeed in educational (or workplace) settings, people need to feel part of the daily atmosphere, not as "guests in someone else's house" (Turner, 2015, p. 345).

Vision of a diverse workforce and value to the profession

What would a "diverse workforce" look like in occupational therapy? The profession is currently comprised mostly of practitioners, educators, and leaders who are white women. Rather than suggest specific desired percentages, we prefer to use broad brush strokes and advocate that every profession benefits from diversity broadly conceived-race, ethnicity, gender, religion, sexual orientation, disability—where each person has the opportunity to offer their own unique, context-focused contribution. Far beyond the obvious ethical and humanist reasons for increasing diversity, the literature is replete with evidence that a more diverse student body or workforce produces creative and competitive advantages while also enhancing a sense of belonging. In social, academic, or professional groups, diversity enhances creativity and competitiveness and positively impacts organizational culture (Surowiecki, 2004; Chavez & Weisinger, 2008). Specific to the context of higher education, research has repeatedly concluded that increasing the diversity of a campus "leads to a broader collection of thoughts, ideas, and opinions …and a wide range of perspectives on a particular issue" (Milem, Chang, & Antonio, 2005, p.7). Chang (2001) examined the relationship between racial prejudice and a variety of educational experiences. He found that lower levels of prejudice promote critical thinking and increases adaptability, key characteristics which enhance academic (and professional) success. Finally, Hurtado et al. (2003) found that individuals who are educated in more diverse environments are more likely to work and live in ethnically diverse settings post-graduation.

In terms of clinical practice, therapists will be called upon to deliver more services in community and population environments where a public health orientation will be critical. Social determinants of health and health disparities disproportionately impact underrepresented populations. Three distinct realities underpin the need for having a diverse workforce: (a) Under-represented minority health professionals disproportionately serve minority and other medically underserved populations; (b) minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity; and (c) non-English speaking patients experience better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner, particularly in mental health care (Sullivan Commission on Diversity in the Healthcare Workforce, 2004). These findings suggest that increased diversity within health care will potentially lead to improved public health by increasing opportunities for minority patients to see practitioners with whom they share a common race, ethnicity or language. Race, ethnicity, and language concordance, which are associated with better patient-practitioner relationships and communication, may increase patients' likelihood of receiving and accepting appropriate care. That being said, it is equally important to avoid creating a situation where, for example, only African-American occupational therapists treat African-American clients. The point here is that, ideally, all occupational therapists should be trained to deliver quality services for all clients. While it is likely that occupational therapists have more frequent contact with diverse clients than other careers, it is essential to remember that diversity and inclusion are issues which, as rooted in institutional structures, are very relevant to society as a whole, and not solely the therapeutic province of professions which serve people with difficulties living their daily lives. Cultural awareness and competence with individual client care are essential, but it is those spaces where occupational therapy and social structures meet—advocacy, policy, perception, climate—are where we must focus our efforts. In an increasingly dynamic and competitive healthcare environment, occupational therapy must leverage every opportunity to position itself as a profession which can assist *everyone* in meeting their occupational needs. In coming back to the *Centennial Vision*, the goals of being widely recognized, globally-connected, and diverse are all related—diversity and inclusion can help facilitate wider recognition and global connections.

Where we are: The diversity and inclusion landscape in 2016

Leaders in occupational therapy have been aware of the needs for a diverse workforce and the value of diversity for our clients and colleagues for quite some time. Scholars have brought the topic to the profession's attention on various occasions over the past three decades (Grady, 1995; Black, 2002; Abreu & Peloquin, 2004; Clark, 2013). Since the early nineties, the profession has intermittently placed diversity on its public agenda and provided resources to support efforts such as ad hoc committees for diversity, the Multicultural Affairs Program (which existed from

1991 to1998) and the theme of the 1995 Annual Conference, "Diversity: Our Journey Together" (Black, 2002). Professional publications and offices of the national association have sought to address diversity in a variety of ways. The *Occupational Therapy Practice Framework* stresses culture as a significant factor for consideration in evaluation and intervention (American Occupational Therapy Association, 2014a), educational standards cite related factors as key learning content (American Occupational Therapy Association, 2011), and the *Code of Ethics* supports efforts to serve underrepresented and marginalized populations (American Occupational Therapy Association, 2015). The American Occupational Therapy Association has made a commitment to non-discrimination and inclusion (American Occupational Therapy Association, 2014b) and supported the formation and activities of numerous multicultural networking groups (e.g. the Multicultural, Diversity, and Inclusion (MDI) Network, which includes the National Black Occupational Therapy Caucus and Network of Hispanic Practitioners, among others). In addition, more recent advocacy groups such as the Coalition of Occupational Therapy Advocates for Diversity (COTAD) are being supported nationally by the Association. Much of the occupational therapy literature related to diversity in the profession calls for practitioners to be client-centered, culturally responsive, and to develop cultural competence when serving diverse clients (Munoz, 2007; Balcazar et al, 2009). For example, the American Occupational Therapy Association (2013) *Frequently Asked Questions* sheet regarding diversity concentrates on terminology such as cultural sensitivity and cultural competence in addition to offering informative resources to practitioners. All the above activities are encouraging signs of the genuine commitment the Association has towards increasing awareness of diversity issues impacting the profession (see Table 1).

Certainly, progress has been made. However, notwithstanding better visibility of the issue and valuable initiatives aimed at increasing and celebrating diversity in the profession, data continues to indicate that occupational therapy remains a mostly white profession. From 2010-2012, 87% of occupational therapists were White, 5% were African-American, and 4% were Hispanic (U.S. Department of Health and Human Services, 2014). In 2013, 86% (OTD), 82% (MSOT, and 78% (OTA) of students were White. Only 4% (OTD), 5% (MSOT), and 10% (OTA) were African-American and 4% (OTD), 7% (MSOT), and 11% (OTA) were Hispanic (American Occupational Therapy Association, 2014c). There have been, at best, modest increases in the numbers of underrepresented minority students enrolled. In addition, the latest AOTA Faculty Workforce Survey (2010) indicates similar metrics. Total faculty ethnicity (OTD, MSOT, and OTA) was 89% White, 3% African-American, and 2% Hispanic. This remains an issue of significant concern for the profession, higher education, the clients we serve, and society at large.

Where we must go: Guideposts for action

Diversity, and to a much lesser extent, inclusion, are recognized as issues that occupational therapy must address. However, discussions surrounding these issues must

Table 1. Diversity and inclusion action matrix.

Approach/Context	Value-Added	Mutual Accommodation
Personal	○ Membership in multicultural organizations/groups ○ Cultural caring and competence as practitioner ○ Cultural awareness activities ○ "Acts of Care" from peers and faculty	○ Community service in underserved areas ○ Critical self-appraisal ○ Critique of profession, institutions, society ○ Research/publication on diversity & inclusion issues
Program/Institution	○ Faculty/staff/student awareness training ○ Add diversity & inclusion issues to curricular content ○ Encourage SOTA groups to plan activities to increase awareness and reflection ○ Faculty and peer mentoring programs ○ Faculty development on creating inclusive and "identity safe" classrooms ○ "Talking Circles" with faculty and students to discuss issues of identities, bias, and culture ○ Create community-building activities and programs to intentionally connect underrepresented students ○ Intentional student recruitment efforts for underrepresented groups	○ Make diversity & inclusion explicit elements of strategic plans to ensure accountability ○ Implement reporting systems for discrimination and bias ○ Scholarships and graduate assistantships to add dimensions of diversity ○ Implement learning climate surveys to collect evaluation data ○ Contain costs by reducing credit hours and time to degree ○ Create "Future OT Scholars" programs for underrepresented undergraduates interested in healthcare
Professional	○ *Centennial Vision* content ○ Support advocacy groups (e.g. COTAD) ○ ACOTE standards reflecting culture ○ OTPF (culture) ○ Diverse workforce initiatives ○ Multicultural networking groups (e.g. MDI, NBOTC) ○ Diversity Ad Hoc Committee ○ OT commitment to non-discrimination and inclusion	○ Create Chief Diversity Officer role and infrastructure ○ Increase scope of practice to fully promote a public health/health disparities approach ○ Create a standing Diversity & Inclusion Committee ○ Support part-time, weekend, and evening options for degree programs ○ Include implicit bias, power, privilege, and allyship in ACOTE standards ○ Publish an official position statement on diversity & inclusion

translate into action and be facilitated by a shift in strategic approach, one that nudges professionals beyond the necessary skills of awareness and culturally competent care. The literature describes four cultural models of diversity which illustrate how diversity has typically been addressed in most organizations and institutions of higher education (Plaut, 2002): sameness, common identity, value-added, and mutual accommodation. Among these four models, a rough boundary can be drawn between the sameness and common identity models—which place more focus on assimilation—and the value-added and mutual accommodation models-which bring forward and affirm dimensions of diversity.

In the sameness model "people are people" and diversity is viewed in a relatively superficial manner. The sameness model presumes that the experiences and goals

of all people in a given population (or society) are similar. In the United States (and most Western/European societies), this model is exemplified in the acceptance of the assumption that "all men are created equal." This motto implies that the playing field is level and that individual behavior and hard work are the determinants for success. Race and ethnicity are seen as irrelevant. The decategorization strategy of the sameness model has been the prevalent approach towards diversity, particularly in the United States (Plaut, 2002). The common identity model acknowledges that differences among groups do exist, but should be minimized through creating encompassing identities (Plaut, 2002). This model rests on the idea that differences are diminished because all group members ascribe to common values and goals— the "teamwork" perspective. The strategy employed within the common identity model is to recategorize "group boundaries from *us* and *them* to *we*" (Plaut, 2002, p. 380). While the relevance of teamwork cannot be ignored, it is equally as important that we do not lose sight of the importance of individual differences. Emphasizing "we" while not appreciating "I" may result in feelings of individual disconnectedness and loss of value.

The value-added model suggests that we acknowledge differences in people and groups positively as sources of strength which add significant value to organizations, institutions, and professions (Plaut, 2002). This model shares the common identity acceptance of substantial group differences, but differs in that it does not support recategorization. The mutual accommodation model also agrees that differences between people and groups exist, but that these differences should be accommodated regardless of value-added perceptions. This model legitimizes different experiences and norms, while advocating for changes which create respectful and safe climates where all cultures feel valued and connected. Organizations and institutions should consider the benefits of accommodating cultural differences instead of expecting assimilation (Plaut, 2002).

We propose that the value-added and, particularly, the mutual accommodation models offer the most potential for actionable change. We appreciate that many worthwhile initiatives supporting diversity and inclusion are already occurring in occupational therapy, most fitting conceptually within the value-added context. However, our contention is that the profession needs to be more focused on a mutual accommodation context which creates critical consciousness and the fullest accountability for producing impactful results. Although existing along the same continuum, the prominent distinction between the valued-added and mutual accommodation perspectives lies in moving from conceptual support and awareness to emotional agency and risk. Building a culture of mutual accommodation requires a more explicit focus on doing, stepping outside comfort zones, and making systemic changes in policy and procedures. We also suggest that the mutual accommodation model best supports building and sustaining inclusive workplaces and learning environments, an area where most organizations, institutions, and professions need to place more focus. We have integrated the two models to form a matrix for diversity and inclusion that guides practical action in multiple levels and contexts (see Table 1).

The strategies presented in Table 1 offer actionable ways in which the *Centennial Vision* words "diverse workforce" can be transformed into actions, policies, and accountable goals. Such strategies can occur on the personal, organizational/institutional, or professional levels. For example, at the personal level, Turner (2015) describes "acts of care" which can have "life-changing results and greatly contribute to building an environment that nurtures human and community potential" (p.352). These acts of kindness include pointing out career options, supplying contacts to build networks, and offering advice on processes and feedback on research or practice. Recognizing and confronting one's own implicit biases and advocating for equal transparency from local and professional organizations and policies are additional ways to approach action from a personal standpoint. Organizations and institutions can advance change through faculty and peer mentoring programs or including diversity and inclusion explicitly in strategic planning. Many institutions of higher education use diversity and inclusion training to address organizational climate. Such trainings are often characterized by awareness-raising activities with no substantial follow-up to dig deeper into the underlying causes. However, the mutual accommodation model is best exemplified when training moves beyond awareness to meaningful dialogue across differences, honest critique and plans for change.

Case Study: A model for implementation

The following case study provides one example of how an approach influenced by the mutual accommodation model has been implemented. A College of Health Sciences at Metropolitan University sought to gain a deeper understanding of issues involving diversity and inclusion. They believed to best serve the community in the broadest sense, it was important to first look inside to ensure that the people who study, work and train on their campus felt welcomed, respected and nurtured. To get a better understanding, faculty, staff, postdocs, fellows, residents and students were invited in an anonymous diversity engagement survey. Leaders agreed that the survey could help them assess where they were in terms of diversity and inclusion and how they could improve at the College. There was strong participation in the survey, and the results indicate that race, gender and other factors play a significant role in how we perceive our connection to the College. The results provided a baseline for measuring future progress and showed that under-represented minorities (African-American and Hispanic respondents) were less positive than Caucasian participants, particularly on questions regarding mutual respect, trust in management, and diversity within the school. Asian respondents were as positive as or slightly more positive than Caucasian survey-takers regarding most issues. Women were generally as positive as men in their responses. However, women were less positive than men on questions related to trust in management, and whether people are recognized equally based on their contributions. Younger employees were more positive in their responses than older employees, and employees here less than five years were more positive than those who had worked here longer. Students were generally more positive than those in other groups. The College's goal was to move the diversity and inclusion conversation beyond awareness into action and

institutional climate change. Based upon the survey results, the College instituted several initiatives aimed at improving the campus culture for all College of Health Sciences stakeholders with an emphasis on the under-represented minorities and women. Four diversity and inclusion trainings were developed and made available, as a pilot program, to all College of Health Sciences community members. The training began with a basic awareness to give College stakeholders a rudimentary understanding of campus demographics, historical challenges between groups and to highlight best practices for team work and creating an environment of mutual respect. Subsequent training introduced the concept of unconscious bias and provided tips for mitigating its impact on campus. The third training centered on way to speak up and address bias without projecting blame or guilt. The final training included carousel brainstorming, planning, and assigning accountabilities for facilitating a warmer, more diverse and inclusive environment. The four iterations of diversity and inclusion training laid the foundation for an on-going open dialogue series where self and institutional appraisal was encouraged. The open dialogue series made room for deep and meaningful engagement across differences. The training and subsequent dialogue series received positive evaluations by participants. The College of Health Science's leaders ultimately submitted a proposal for University-wide adoption of the mutual accommodation training model. College of Health Science faculty and staff volunteered to serve as advisors to the University throughout the implementation of the training model.

This case study describes an intentional effort to address diversity and inclusion which was part of a larger University-wide focus to build and sustain a positive and welcoming learning and working environment.

Finally, at the professional level, the mutual accommodation approach can be illustrated through a variety of actions. For example, occupational therapy organizations (both state and national) can provide resources to support advocacy groups and create a chief diversity officer role and associated infrastructure. The Accreditation Council for Occupational Therapy Education could consider infusing educational standards with diversity-related content such as unconscious bias, professional power differentials, and strategies for being an ally for underrepresented groups.

Barriers to change

While supporting the need for a change in strategic approach, we acknowledge that there are barriers, not the least of which are the implicit but rather entrenched biases of personal experience, attitudes, and institutional policies and practices. More specific and common barriers also exist. Diversity and inclusion efforts often fall short when they are not articulated as a central part of the institution's mission statement and fundamentally rooted in day-to-day operations. An individual or institutional mindset that views diversity and inclusion as a threat to excellence or otherwise mutually exclusive can often undermine good intentions and programs designed to improve organizational or campus climate. Gaining access to stakeholders is often challenging due to high demands on their time. The time factor can

be especially disruptive if those stakeholders have not fully recognized the value of a more diverse and inclusive workforce. Within higher education, prohibitive costs, preferential admittance and in-state tuition rates for "local" applicants, few course or degree options for working students and lack of faculty knowledge in creating inclusive classrooms all can provide obstacles to more diverse student and professional populations. The relative lack of public recognition of what occupational therapists do and their distinct value to society can limit who chooses to enter the profession, particularly those from underrepresented groups who do not see their faces embodied in the current professional makeup.

Conclusion

Value-added initiatives which promote diversity are a necessary start, but efforts must not stop there. The existence of institutionalized racism is often dismissed as a vestige of the pre-Civil Rights era. Research on the topic would argue otherwise, and indicates that experiences of discrimination and bias still exist and impact minorities in significant ways, including creating and sustaining health disparities (Krieger, 2003). Expecting educational programs to equip students to address a problem as ingrained and complex as institutionalized racism is not necessarily realistic. However, educators and professional leaders *can* support a critical stance where practitioners, researchers, academicians, and students unearth and struggle with shifting identities, unconscious bias, privilege, and power. These courageous conversations are essential to foster growth and encourage participation in learning experiences. We suggest that of all the diversity models discussed, the mutual accommodation approach provides the most solid foundation for a more critically reflective paradigm. It allows, even encourages, self-appraisal and critique of the profession and social institutions. Such a context confronts the limitations of perceiving diversity only from a sensitivity and competence standpoint (Tervalon, 2003; Jenks, 2011)and promotes inclusive settings which can attract and retain a more diverse and innovative workforce.Emergence of new practice areas, an increasing focus on public health and health disparities, globalization, and the long-term sustainability of the profession require diverse professional representation *paired with* inclusive learning and working climates. The pathway from where we are to where we must go starts with open and honest reflection on the individual, institutional, and professional levels. Honest reflection alone, however, is insufficient if not followed by understanding, commitment and action.

Acknowledgments

Declaration of Interest

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