Cultural Competency Tool Kit: An Overview

Introduction

The Multicultural, Diversity, and Inclusion (MDI) Network is a network of independent groups that collectively support the increase of diversity and inclusion in occupational therapy. The MDI Tool Kit for Cultural Competence provides a selection of resources to understanding the specific values, norms, beliefs, attitudes, and behaviors associated with different cultural groups.

Why We Need Multicultural Competency

Demographics: The population of the United States in 2013 is reported at 316,128,839 (U.S. Census Bureau, 2014). Demographic distribution based on race/ethnicity is as follows: White 77.7%; Hispanic Latino 17.1%; Black or African American 13.2%; Asian 5.3%; two or more races 2.4%; American Indian and Alaska Native 1.2%; Native Hawaiian and Pacific Islander 0.2% and 19% are individuals with disabilities.

In the next 50 years, the U.S. is projected to be a plurality nation, where the non-Hispanic white population will be the largest single group, but no group will be in the majority.

Health inequities: The prevalence and distribution of illness, premature death, and disability is disproportionately represented in certain populations that are considered vulnerable on the basis of race/ethnicity, socioeconomic status, geography, gender, age, disability status, sexual orientation, and primary language. Factors that contribute to health, also known as *health determinants* are genes and biology, health services, health behaviors, physical environment, and social environment (Centers for Disease Control and Prevention [CDC], 2014). The contribution of biology and health behaviors to health is approximately 25%, and access to health care (or lack thereof) is no more than 20% (CDC, 2014). The root causes of health inequities are the consequence of complex interactions of these health determinants.

Attitudinal barriers: Attitudes are cultural products and influence how we think, feel, and behave toward others who are different. Social attitude is an environmental factor that impacts health, well-being, and ability to participate in social situations (World Health Organization, 2002). Practitioners' cultural identity influences their attitudes and behaviors towards their clients. In a landmark publication, the unconscious bias and stereotypes held by providers was identified as the cause of differential treatment and quality of care provided to minorities and non-minorities with equal access to care and no differences in their needs and preferences for treatment (Institutes of Medicine, 2001).

Social exclusion impacts health negatively; people want to belong and feel accepted. Transcending differences and recognizing the common humanity we share helps create a socially-inclusive society.

Cultural competency education is expected to improve health outcomes by enhancing the provider's knowledge, skills, and attitudes toward diverse clients and enhancing the ability to provide culturally responsive and effective services.

What is Multicultural Competency?

Multicultural competency means having the ability to function effectively in cross-cultural interactions with clients who are from a different cultural group. A critique of cultural "competency" has been that it implies that there exists an end-point at which one becomes competent (Gupta, 2008). However, given the complexity of both culture and human behaviors, it is important to recognize that acquiring cultural competency is a *life-long process*. Some alternate terminologies associated with the idea of cultural effectiveness are represented in the table below.

Terminology	Definitions & key reference
Cultural Competence	"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13).
Cultural Responsiveness	Cultural responsiveness is about reciprocity and mutuality. The process involves exploring differences, being open to valuing clients' knowledge and expertise, and recognizing the unique cultural identity of each individual client (Munoz, 2007).
Cultural Humility	Cultural humility is an attitude and process by which providers strive to address issues of power differences between professionals and clients, value and respect clients by continuous engagement in self-reflection, and self-critique as life-long learners and reflective practitioners (Tervalon & Murray-Garcia, 1998).
Cultural Intelligence	Cultural intelligence is the ability to interact effectively with culturally different clients, and it relies on cultural metacognition—knowledge of your own attitudes, values, and skills, and those of the clients, makes for an effective encounter (Thomas et al., 2008).
Cultural Safety	Cultural safety is a sociopolitical idea about the unconscious and unspoken assumptions of power held by health providers of particular groups that have been historically marginalized. It is about the trust and safety a client experiences when treated with respect and understanding, and is included in the decision-making process. Providers recognize their own culture, beliefs, and attitudes, recognizing that building trust and empowering clients requires power sharing (Canadian Association of Occupational Therapists, 2011).

Influential Theories Relevant to Culture

The familiar image of culture as an iceberg shows that most important and deeper meanings of culture are hidden from view. Culture shapes our beliefs and world view. Values are at the core of differences in cultural beliefs, attitudes, and behaviors. The following are some dominant and influential theories.

- Schwartz's Theory of Basic Values identifies *ten core universal values* that are common to all cultures, with defining goals and behaviors that are essential for human survival and existence as socially organized groups (Schwartz, 2012). The differences between cultures lie in how these values are prioritized and the behaviors they elicit.
- Hofstede's Cultural Dimensions Theory (2001) provides a systematic framework for five cultural dimensions shared by all cultures: Power Distance (equality versus hierarchy), Individualism (individual freedoms versus collective responsibilities), Uncertainty Avoidance (informal versus formal), Masculinity (competition versus collaboration), and Time Orientation (short-term versus long-term).
- Hall (1976) classified cultures on the basis of communication as high-context (HC) cultures and low-context (LC) cultures. The communication style of HC culture is indirect and meaning is implicit. Communication in LC culture is direct and explicit. The U.S. is a low context culture.

It is best to view these cultural characteristics as lying along a continuum rather than as polar opposites. For example, it is the relative degrees of individualism versus collectivism that differentiates cultural groups. Individuals from a collectivist culture are still individuals, but the degree to which they factor others into their decisions is different from those from a strong individualistic perspective.

Culture and Individual Identity

Client-centered practice dictates that we treat each client as a unique being. Some important ideas to keep in mind in cross-cultural interactions are the following:

- Culture is dynamic and complex and is influenced by outside forces such as technology and globalization.
- Cultural influences one's identity, but identity is multilayered and is derived from multiple sources. A client typically holds multiple identities based on life circumstances and experiences. These identities stem from affiliations to family, community, profession, religion, nation, and others.
- A client's identity is a product of intersections of race/ethnicity, education, socioeconomic class, sex, age, sexual orientation, (dis)ability, religion, etc.

Implications for Practice

How do we use our knowledge, skills, and attitudes to provide culturally responsive and culturally effective care? Knowledge about key cultural characteristics is helpful, but it is

important to know that over time people are acculturated and socialized to the larger context and dominant ways of doing and being. Acculturation is a process in which members of one cultural group adopt the beliefs and behaviors of another group (Berry, 1997). The extent to which individuals become acculturated varies; social integration requires a certain degree of acculturation from diverse cultural groups as well as an inclusive attitude by the dominant social groups.

What You Will Find in this Tool Kit

The MDI is a network of independent groups of various diverse identity and affiliations based on race/ethnicity; disability; sexual orientation; and religious affiliation. The links below provide specific information and resources for each of these groups.

Multicultural Networking Groups:

- Asian/Pacific Heritage Occupational Therapy Association (APHOTA)
- National Black Occupational Therapy Caucus (NBOTC)
- Network for Lesbian, Gay, Bisexual, and Transgender Concerns in Occupational Therapy (The Network)
- Network for Occupational Therapy Practitioners with Disabilities and Their Supporters (NOTPD)
- Occupational Therapy for Native Americans (OTNA)
- Orthodox Jewish Occupational Therapy Chavursa (OJOTC)
- Terapia Ocupacional para Diversidad, Oportunidad y Solidaridad (TODOS) Network of Hispanic Practitioners

References

Berry, J. W. (1997). Immigration, acculturation and adaptation. *Applied Psychology: An International Review, 46*, 5–68.

Canadian Association of Occupational Therapists. (2011). CAOT Position Statement: Occupational therapy and cultural safety. Retrieved from http://www.caot.ca/pdfs/positionstate/PS_Cultural.pdf

Centers for Disease Control and Prevention (2014). Social determinants of health. Retrieved from http://www.cdc.gov/socialdeterminants/FAQ.html#a

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care* (Vol. 1). Washington, DC: Georgetown Center. Retrieved from http://files.eric.ed.gov/fulltext/ED330171.pdf

Gupta, J. (2008, September). Reflections of one educator on teaching cultural competence. *Education Special Interest Section Quarterly, 18*(3), 3–4.

Hall, E. T. (1976). *Beyond culture.* New York: Anchor Books.

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations.* Thousand Oaks, CA: Sage.

Institutes of Medicine. (2001). *Unequal treatment: Confronting racial and ethnic disparities in healthcare.* Washington, DC: National Academies Press.

Munoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International, 14*(4), 256–280. http://dx.doi.org/ 10.1002/oti.238

Schwartz, S. H. (2012). An overview of Schwartz theory of basic values. *Online Readings in Psychology & Culture, 2*(1). http://dx.doi.org/10.9707/2307-0919.1116

Tervalon, M., &Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 17–25.

Thomas, D. C., Elron, E., Stahl, G., Ekelund, B. Z., Ravlin, E. C., Cerdin, J-L.,... Lazarova, M.B. (2008). Cultural intelligence: Domain and assessment. *International Journal of Cross Cultural Management, 8*, 123–143. http://dx.doi.org/10.1177/1470595808091787

U.S. Census Bureau. (2014). U.S. state and country quick facts. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

World Health Organization. (2002). International classification of functioning, disability and health. Retrieved from http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf

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Asian/Pacific Heritage Occupational Therapy Association (APHOTA)

Mission
The mission of the organization is to create a venue for occupational therapy practitioners who are committed to supporting Asian/Pacific practitioners and advancing a greater understanding of Asian/Pacific cultural issues affecting occupational therapy practice.

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Key Facts on Asian Americans and Pacific Islanders (AAPI)

Asian Americans and Pacific Islanders (AAPI) are not a homogeneous group. They are diverse ethnic groups originating from approximately **28** different Asian countries from the Far East, Southeast Asia, and the Indian subcontinent; Pacific Islanders hail from **19** Pacific Island nations. AAPIs make up one of the fastest growing racial groups in the U.S and about a third of the one million legal immigrants who enter the U.S. annually. Nearly two thirds of AAPIs who reside in the U.S. are foreign-born.

- **Demographics**

Today there are 12 million AAPIs living in the U.S who represent 5% of the total population of the country. The distribution is as follows:

- Large group, more than 3 million each: Chinese (not including Taiwanese), Asian Indian, Filipino
- Mid-size group, between 1 and 2 million each: Vietnamese, Korean, Japanese
- Small group, less than 1 million each: Other Asian not specified, Pakistani, Cambodian, Thai, Laotian, Hmong, Taiwanese, Bangladeshi
- Very small group, below100,000 each: Burmese, Indonesian, Nepalese, Sri Lankan, Malaysian, Bhutanese, Mongolian, Okinawan, Singaporean
- Largest in numbers are Chinese and Asian Indians, and the smallest groups under 50,000 are Sri Lankan, Malaysian, Bhutanese, Mongolian, Okinawan. Singaporean is the smallest, at only 5,347.

❖ For a visual representation of demographics of AAPI in the U.S., click here.

- **Languages**

  There are many different countries represented in this group, and each has its own dominant languages and many dialects. For instance, the subcontinent of India has 22 major languages written in 13 different scripts, with more than 720 dialects. The official Indian languages are Hindi (with approximately 420 million speakers) and English, which is also widely spoken. China has 8 major dialect groups and the official language that is spoken in Beijing is a form of Mandarin.

  - Nearly one out of four AAPI students is Limited English Proficient and/or lives in a linguistically isolated household where parents have limited English proficiency.
  - AAPIs who are not proficient in English may not communicate effectively with health care providers.

  However because Asian Americans as a group are well educated, most do not experience language difficulties in the context of health care.

Education & Employment

- The Model Minority Myth: The danger of the model minority myth stereotype is that it assumes that *all* Asian Americans enjoy a high socioeconomic status, and are well educated and successfully integrated.
  - In 2013, the official poverty rate for the country was 14.5%, with 45.3 million Americans living in poverty. A comparison of Census Poverty data from 2013 revealed the following:

Race	Percent of Total Population	Poverty rate
Whites	62.4%	9.6%
Hispanics	17%	23.5%

Blacks	13.2%	27.2%
AAPIs	5.5%	10.5%

- o The high school dropout rate among Southeast Asian Americans is staggering: 40% of Hmong, 38% of Laotian, and 35% of Cambodian populations do not complete high school. Only 14% of Native Hawaiians and Pacific Islanders 25 years of age and older have at least a bachelor's degree, compared with 27% for the total population, and 49% of the Asian American population.
- Many Asian Americans *have* achieved the American Dream of earning a good education and having financial stability.
  - o Asian Americans represent the largest numbers in the nation with a bachelor's degree or more (49%) compared with the general U.S. population (28%), Whites (31%), Blacks (18%), and Hispanics (13%).
  - o Asian Americans are the highest-income, best-educated, and fastest-growing racial group in the United States (Pew Research Center, 2013).
  - o Median household income differs greatly by Asian group. For example, Asian Indian median income in 2012 was $96,782; for Bangladeshi, it was $44,293. Overall, Asian American median income is $66,000 compared with the income of the general population ($49,000) and Whites ($54,000).

Religious Affiliation

According to the Pew Research Center survey on Asian Americans:

- Overall, 39% of Asian Americans say religion is very important in their lives, compared with 58% of the U.S. general public.
- In total, 26% of Asian Americans are unaffiliated, 22% are Protestant, 19% are Catholic, 14% are Buddhist, 10% are Hindu, 4% are Muslim, and 1% are Sikh. The breakdown is as follows:
  - o About half of Chinese are unaffiliated
  - o Most Filipinos are Catholic
  - o About half of Indians are Hindu
  - o Most Koreans are Protestant
  - o Vietnamese are largely Buddhists
  - o Among Japanese Americans, no single group is dominant—38% are Christian, 32% are unaffiliated, and 25% are Buddhist

General Cultural Attributes

Asian Americans trace their roots from many countries in the Far East, Southeast Asia, and the Indian subcontinent. Each country has its own unique history, culture, language, religious beliefs, economic and demographic traits, social and political values, and reasons for its citizens to come to America.

Despite the diversity, Asian Americans have some distinctive traits as a whole when compared with the U.S. general population:

- Collectivist attitude: Strong emphasis on family—Some of the most important things in life for Asian Americans are related to family:
  - More than half (54%) value a successful marriage
  - They are more likely than all American adults to be married (59% vs. 51%)
  - Children are less likely to have an unmarried mother (16% vs. 41% of general population)
  - Children are more likely to be raised in a household with two married parents (80% vs. 63%)
  - Two-thirds (67%) value parenting
  - Many have multi-generational households (28%)
  - Respect for parents—two-thirds say parents should have a lot or some influence in choosing one's profession (66%) and spouse (61%)
- Great value placed on harmony: More collectivist in beliefs and hence even with acculturation, most Asians place high value on family, which includes extended family.
- Conformity to norms and social expectations is valued.
- Work ethic: 93% describe people of their home countries living in the U.S. as hard working.
  - Parenting: Asian-American parents tend to put pressure on their children to do well in school. Education is seen as a means of improving social standing.
  - Check out Battle Hymn of the Tiger Mother, a comic memoir about strict parenting by Yale Law Professor Amy Chua that triggered a spirited national debate about cultural differences in parenting norms.

For more information see: Pew Research Center: The Rise of the Asian Americans

Health & Health Care
- Leading causes of death:
  - Cancer is the leading cause of death for AAPIs. Cervical cancer incidence rates are among the highest in the U.S. for Laotian, Samoan, Vietnamese, and Cambodian women.
  - Heart disease, stroke, and diabetes also rank high.
  - Hepatitis B chronically infects about 1.3–1.5 million people in the U.S., and AAPIs account for over half of the chronic hepatitis B cases and deaths.
  - In Hawaii, Asians, Native Hawaiians, and other Pacific Islanders age 20 years or older are more than two times as likely to have diagnosed diabetes as White residents of Hawaii of similar age.
- Mental health problems in the Asian American community are disturbingly high, yet the services are inadequate.
  - Asian women aged 65 years and over have the highest suicide rate in the country compared with any other population in that age group.

- Asian American adolescent girls have the highest rates of depressive symptoms compared with girls of other ethnicities.
- Southeast Asian refugees are at risk of post-traumatic stress disorder (PTSD) associated with trauma experienced before and after immigration to the United States.
- Health care barriers:
  - Asian Americans with limited English proficiency have difficulties understanding the U.S. health care system, accessing health care services, and communicating with health care providers.
  - Many Asian Americans believe that their physicians do not understand their culture and values.
  - Varying cultural values and beliefs of disease sometimes put constraints on an individual from seeking proper care. Use of traditional medicine delays accessing health care and contributes to the diagnosis of diseases in the later stages, leading to untreatable conditions.

For more information: Centers for Disease Control: Asian Americans

National Library of Medicine: Asian American Health & Materials in Asian Languages

Education modules from Stanford University on Elder care
Health and Health Care for CHINESE-AMERICAN ELDERS
Health and Health Care for KOREAN-AMERICAN ELDERS
Health and Health Care for Filipino Elders
Health and Health Care for Asian Indian Elders

National Asian Pacific American Families Against Substance Abuse: Founded in 1988, NAPAFASA involves service providers, families, and youth in efforts to reach API communities to promote health and social justice and to reduce substance abuse and related problems.

Asian & Pacific Islander American Health Forum (APIAHF): Policy and Advocacy

The Association of Asian Pacific Community Health Organizations

National AAPI Mental Health Association convenes service providers, evaluators, and youth to identify best practice for AAPI groups.

Scholarly Journals

Journal of Asian American Studies (JAAS): Original scholarly articles about the multidimensional experiences of Asian Americans and Asians.

Journal of Immigrant and Minority Health: Peer-reviewed original research pertaining to immigrant health.

Asian American Journal of Psychology: Dedicated to research, practice, advocacy, education, and policy within Asian American psychology.

Journal of Transcultural Nursing: Peer-reviewed journal that offers theoretical approaches and current research findings that have direct implications for the delivery of culturally

congruent health care and the preparation of health care professionals who will provide that care.

[Medical Care:](#) Original, peer-reviewed papers documenting the most current developments in the rapidly changing field of health care.

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National Black Occupational Therapy Caucus (NBOTC)

Mission

The National Black Occupational Therapy Caucus is a network and community comprised of a dynamic group of practitioners, educators, researchers, and students of African Descent who work to promote the success of our colleagues within the profession and advocate for equitable services for consumers in our communities of interest.

The objectives of NBOTC are:

- •Increase communication among African-American therapists, assistants, and students

- •Increase student recruitment, retention, and certification

- •Promote equal opportunity in employment and education

- •Encourage professional association participation and leadership

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Background

The African-American and/or Black American ethnic group in the United States is a diverse population that is composed of descendants from many areas in the world, including Africa, the West Indies, and South and Central America. The African American culture reflects a very rich history, filled with struggles, innovations, pride, leadership, and traditions. Most of the descendants from the continent of Africa arrived to the U.S. through the Middle Passage during the Trans-Atlantic slave trade between the 16th and19[th] centuries (PBS, n.d.).

The Middle Passage was a three-part trading system that began and ended in Europe. A ship leaving Europe carrying supplies (e.g., gunpowder and weapons) sailed to Africa for

trade. Africans were captured and enslaved in exchange for these goods and traveled across the Atlantic Ocean to North American destinations. The African slaves were bought and sold in the Americas for different goods and products (e.g., sugar, tobacco) that were loaded onto the ship and transported back to Europe. It is estimated that as many as 12 million men, women, and children endured the trip across the seas in the Middle Passage (PBS, n.d.). Much of the early slave history was not written because slaves were not permitted to learn to read and write. African American history was passed down through oral storytelling and songs until the stories could be written down for preservation.

Key Facts About African Americans

Demographics

- The Centers for Disease Control and Prevention (CDC) estimated that in 2013 the population of people who classify themselves as African American (including self-reported persons of more than one race) to be 45 million. This is represents 15.2% of the total U.S. population (CDC, n.d.).
- The 2010 *Census Brief* "The Black Population: 2010" (U.S. Census Bureau, 2011), defines *Black or African American* as a person having origins in any of the Black racial groups of African American; Sub-Saharan African such as from Kenya and Nigeria; and Afro-Caribbean, such as from Haiti and Jamaica.
- The U.S. Census Bureau forecasts that by 2060, the Black population will be 74.5 million (or 17.9% of the total U.S. population) (CDC, 2015).
- In 2013, the largest percentages of African (Black) American residents per total population live in the District of Columbia (51%), and Mississippi (38%). The largest number of African (Black) American residents live in New York (3.7 million) (CDC, n.d.).
- 2.2 million African (Black) American veterans served this country in the U.S. armed forces in 2013 (CDC, 2015).
- The African (Black) American male population in 2013 was recorded as 21.5 million. This was 48% of the total African (Black) American population, with a median age of 31 years (BlackDemographics.com, n.d.a). The African (Black) American female population in 2013 was recorded as 23.5 million (BlackDemographics.com, n.d.a). This was 52% of the total African (Black) American population, with a median age of 35 years (BlackDemographics.com, n.d.a). The largest number by population of African (Black) Americans live in states in the south, southeast, and mid-Atlantic regions (U.S. Census Bureau, 2011).

For additional information, charts, and tables detailing the geographical distribution of African (Black) Americans by population in the United States, view The Black Population: 2010.

Education and Employment

According to the U.S. Census Bureau (2011, 2013), 48% of African American men age 25 and older attended college. However, half of them did not complete a degree (compared with 58% of all men who attended college). African American women have been more successful than their male counterparts in terms of education: 57% of African American women age 25 and older attended college, and 22% completed college with a bachelor's degree (compared with 30% of all women who attended college).

The median income for African American women in 2013 was $33,780, and 36% of African American working women held full-time jobs. The breakdown of these types of jobs is:

- White collar (management, legal, education, business, and computers): 64%.
- Blue collar (construction, maintenance and repair, installation, and transportation): 8%
- Service occupations (health care support, food preparation, and serving): 28% (BlackDemographics.com, n.d.b)

The median income for African American men in 2013 was $37,290, and 37% of African American men held full-time jobs. The breakdown of these types of jobs is:

- White collar (management, legal, education, business, and computers): 42%.
- Blue collar (construction, maintenance and repair, installation, and transportation): 36%
- Service occupations (health care support, food preparation, and serving): 23% (BlackDemographics.com, n.d.c)

The U.S. Justice Department, Bureau of Justice Statistics (2014), issued a data report from their National Prisoner Statistics program noting that in 2013 African American males had the highest percentage of imprisonment rates of all males (37%). In addition to those males who also are classified as ex-offenders between the ages of 18 and 64, this negatively affects the labor force and employment numbers for African American males as well as the increased number of single female parent households.

Health Disparities

The leading causes of death for African Americans are heart disease, cancer, stroke, diabetes and unintentional injuries (e.g., motor vehicle injuries) (CDC, 2015).

Smoking and tobacco use, asthma, teen pregnancy, obesity, high cholesterol, and HIV are also areas identified by the CDC Health Disparities and Inequalities Report (CDC, 2013) as conditions that affect life expectancy, death rates, and other conditions and behaviors affecting African Americans today.

Religion

African Americans hold strong views and values when it comes to religion. The Pew Research Center (2009) summarized the results of a 2008 study showing that African Americans are

"markedly more religions on a variety of measures than the U.S. population as a whole, including level of affiliation with a religion, attendance at religions services, frequency of prayer and religion's importance in life."

The Pew Center's summary also noted that:

- On the basis of attending religious services at least once a week, praying on a daily basis, and the belief that God exits, African Americans are "considered the most religiously committed racial or ethnic group in the nation."
- 83% of African Americans consider themselves to be Christians, with 1% identifying themselves as Muslims. The breakdown of the top five religions affiliations identified by African Americans by percentage are:
  - 45% Baptist
  - 12% Non religious
  - 8% Pentecostal
  - 7% Other Protestant
  - 5% Methodist

Resources

The following websites provide research, documentaries, government data, and cross cultural guidance on diversity issues as they relate to African Americans

1. Program for Research on Black Americans
   PRBA seeks to collect, analyze, and interpret empirical data on African Americans as well as international data on people of African descent. Additionally, PRBA provides research and training opportunities to scholars, graduate students, and graduate assistants of African descent.

2. Stanford Ethnogeriatric Curriculum Module
   The health conditions in the African American or Black elder population in the U.S. are discussed in this module. An emphasis is placed on historical and traditional influences on this population's health and health care. This module is divided into the following segments:
   - Assessment
   - Prevention and treatment
   - Access and utilization
   - Culturally appropriate geriatric care

3. African American Community Health Fact Sheet Written by NAMI
   This mental health sheet summarizes pertinent factors of mental illness in the African American community such as diagnosis, treatment, and cultural sensitivity.

4. Race: The Power of an Illusion
   A newsreel series and accompanying website on the Public Broadcasting Service (PBS) navigates viewers through the topic of race and its effect on social, economic, and political paradigms.

5. *Not in Our Town: Tools to Fight Hate*
   A documentary series and campaign by the Working Group educating and informing organizations through grassroots and educational outreach on how to prevent and respond to hate crimes.

6. PBS Frontline Documentary: A Class Divided
   Examines how a third grade class learns a daring lesson in discrimination that has had an impact for more than 30 years.

7. Culture at Work
   A website designed to help one negotiate difficult issues in the work setting, especially in cross-cultural situations.

8. Office of Minority Health
   A website created by the U.S. Department of Health and Human Services designed to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities.

9. CDC—Black or African American Populations
   Minority health report developed and compiled from the 2010 U.S. Census by the Centers for Disease Control and Prevention describing African American demographics, leading causes of death, health statistics and disparities, resources, and funding.

References

BlackDemographics.com. (n.d.a). 2013 census black population estimates. Retrieved from http://blackdemographics.com/population/

BlackDemographics.com. (n.d.b). African American women. Retrieved from http://blackdemographics.com/black-women-statistics/

BlackDemographics.com. (n.d.c). Black men. Retrieved from http://blackdemographics.com/black-male-statistics/

Centers for Disease Control and Prevention. (2013). CDC health disparities & inequalities report. Retrieved from http://www.cdc.gov/minorityhealth/CHDIReport.html

Centers for Disease Control and Prevention. (n.d.). *Black or African American populations.* Retrieved from http://www.cdc.gov/minorityhealth/populations/REMP/black.html

Centers for Disease Control and Prevention, (2015*). Newsroom. Black (African-American) History Month: February 2015*. Retrieved from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff01.html

PBS. (n.d.). Africans in America: Part 1, The terrible transformation. Retrieved from http://www.pbs.org/wgbh/aia/part1/index.html

Pew Research Center. (2009). A religious portrait of African Americans. Retrieved from http://www.pewforum.org/2009/01/30/a-religious-portrait-of-african-americans/

U.S. Census Bureau. (2011). *2010 Census briefs: The black population.* Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf

U.S. Census Bureau. (2013). American community survey. Retrieved from http://www.census.gov/acs/www/data_documentation/2013_release/

U.S. Department of Justice, Bureau of Justice Statistics. (2014, September). Prisoners in 2013. Retrieved from http://www.bjs.gov/content/pub/pdf/p13.pdf

Network for Lesbian, Gay, Bisexual & Transgender Concerns in Occupational Therapy
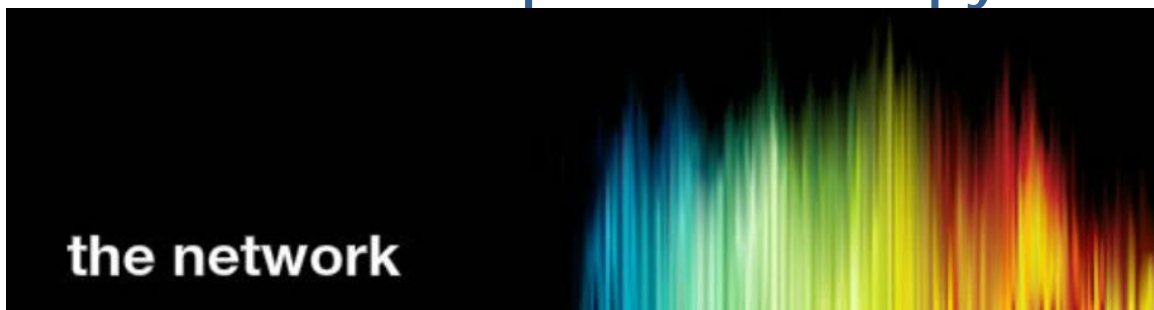
Mission

The mission of the Network is to create the means for members of the occupational therapy professional community who are committed to advancing the understanding of sexual orientation issues to identify, support, and mentor one another and to promote research in occupational therapy.

Purpose

The Purpose of the Network is to:
- Provide a consistent voice to AOTA, and state and local professional organizations regarding the needs and concerns of LGBT practitioners, students, and consumers
- Support and mentor one another, and promote LGBT representation and leadership in local, state, and national decision-making bodies
- Promote the exploration of careers in occupational therapy by LGBT individuals
- Promote scholarship and research by and related to LGBT individuals within the profession of occupational therapy

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Website http://www.otnetwork.org/

"LGBT individuals encompass all races and ethnicities, religions, and social classes. Sexual orientation and gender identity questions are not asked on most national or state surveys, making it difficult to estimate the number of LGBT individuals and their health needs." (Healthy People 2020, n.d.)

Research suggests that LGBT individuals endure health disparities, which increase the likeliness of psychiatric disorders, substance abuse, and suicide, and they have more limited interactions with the health care system due to fear of discrimination (Healthy People 2020, n.d.).

Suggestions for ways to interact with clients/patients to decrease discrimination:

1. DO assume that you will have LGBT clients/patients.
2. DO remember that sexual orientation and gender identity are only two aspects of a person's overall identity and life experience, and every person's experience is unique.
3. DO ask your clients/patients about their sexual orientation and gender identity (including pronoun preferences) in a respectful, safe, and confidential manner.
4. DO NOT assume you can identify LGBT individuals by appearance or other external characteristics.
5. DO NOT assume that treating everyone the same, regardless of sexual orientation or gender identity, is effective or will make LGBT individuals feel safe or welcomed (Services for Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, 2012).

<u>Health Disparities and Access to Health Services</u>

The more informed health care professionals are, the more comfortable LGBT patients and clients will feel in an environment that often can be alienating, disrespectful, and traumatic. In order to create a more welcoming environment, it is essential to look at each aspect of the health care environment, from the front desk to the clinical level.

"LGBT people don't necessarily feel they need special treatment, but they don't want to have to explain or justify their lives or relationships, especially at a time when they may be in crisis or in need of personal care and support. Instead they want to feel comfortable, and that they are in an environment where people understand LGBT issues and where social care practitioners are confident to work in an inclusive, anti-discriminatory way" (Social Care Institute for Excellence, n.d.).

<u>References</u>

GLMA. (n.d.). Part 2: Creating a welcoming and safe environment for LGBT people and families. Retrieved from http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=1025&grandparentID=534&parentID=940&nodeID=1)

Healthy People 2020. (n.d.). Lesbian, gay, bisexual, and transgender health. (n.d.). Retrieved March 23, 2015, from http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25#one)

Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders. (2012). Inclusive services for LGBT older adults: A practical guide to creating welcoming agencies. Retrieved from http://sageusa.org/resources/publications.cfm?ID=107

Social Care Institute for Excellence. (n.d.). At a glance 42: Personalisation briefing: Working with lesbian, gay, bisexual and transgender people. Retrieved from http://www.scie.org.uk/publications/ataglance/ataglance42.asp

Key Resources

Health Professionals Advancing LGBT Equality: www.glma.org

Substance Abuse and Mental Health Services Administration (SAMHSA): http://captus.samhsa.gov/access-resources/top-health-issues-lgbt-populations-information-and-resource-kit-samhsa

Resource kit and report on health issues for LGBT individuals: National Resource Center on LGBT Aging www.lgbtagingcenter.org

Services and Advocacy for GLBT Elders (SAGE): http://sageusa.org

Gay, Lesbian, & Straight Education Network (GLSEN): http://www.glsen.org/

Resources especially relevant for school-based practice and understanding transgender and gender non-conforming issues: Gender Spectrum Education and Training: http://www.genderspectrum.org

Resources Specific to Lesbians and Occupational Therapy:

Jackson, J. (2000). Understanding the experience of noninclusive occupational therapy clinics: Lesbians' perspectives. *American Journal of Occupational Therapy*, *54*, 26–35. http://dx.doi.org/10.5014/ajot.54.1.26

Javaherian, H., Christy, A., & Boehringer, M. (2007). Occupational therapy practitioners' comfort levels and preparedness in working with individuals who are gay, lesbian, or bisexual. *Journal of Allied Health*, *37*(3), 150–155.

Network of OT Practitioners with Disabilities & Supporters

Mission

The Network of Occupational Therapy Practitioners with Disabilities and Supporters (NOTPD) is an independent organization and member of the AOTA-recognized Multicultural, Diversity, & Inclusion Network. The NOTPD advocates for equal access and inclusion of all occupational therapy practitioners, students, and members of the public in AOTA-sponsored events, programs, and services as well as in the occupational therapy profession as a whole. The NOTPD serves as a voice for its members on disability issues and is a resource on disability culture, legislation, and advocacy. The NOTPD's ultimate goal is to make AOTA members and the occupational therapy profession world leaders in respecting and promoting equal access and inclusion of all people.

Chair: Sandy Hanebrink; wheeldogs@yahoo.com

Website: www.notpd.org

Demographics

Nearly 1in 5 people in the United States have a disability. About 56.7 million people—19% of the population—had a disability in 2010, according to a broad definition of disability, with more than half of them reporting the disability was severe, according to a comprehensive report by the U.S. Census Bureau (2012).

The report, Americans with Disabilities: 2010, presents estimates of disability status and type. According to the report, the total number of people with a disability increased by 2.2 million from 2005 to 2010, but the percentage remained statistically unchanged. Both the number and percentage of those with a severe disability rose, however. Likewise, the number and percentage of those needing assistance also both increased. (U.S. Census Bureau, 2012).

The U.S. Department of Labor reports that in 2015, people with disabilities represent 19.8% of the population versus people without disabilities, at **68.2%.** Yet the unemployment rate for people with disabilities is **11.2%,** versus **5.6%** for People without disabilities. People with disabilities are the most over educated, under-employed and unemployed population in the world.

People with Disabilities are an Uncategorized Health Disparity Population and not included in federal requirements and public health disparities data. Current federal law does not consider individuals with disabilities as a "medically underserved population." It also does not include disabilities under requirements for cultural competence and fails to recognize disabilities under any federal program that addresses health disparities.

Overall, people with disabilities have been reported to experience fair or poor health approximately four times more than their peers without disabilities. In addition, a disproportionate percentage of people with disabilities

experience the social determinants of poor health (CDC Health Disparities and Inequities Report United States 2011).

Disability Prevalence by Race/Ethnicity and Percentage with Fair or Poor Health

Race/Ethnicity	% with a Disability	% with a Disability Reporting Fair or Poor Health	% without a Disability Reporting Fair or Poor Health
White	21.6	36.4	5.8
Black/African American	22.6	47.6	13.4
Hispanic/Latino	17.5	54.1	23.2
Asian	10.5	31.5	8.5
Nat. Haw./Pac. Island	17.9	47.6	13.4
Multi-Race	30.6	45.3	9.6
Total	21.1	40.0	9.2

Source: Centers for Disease Control and Prevention, CDC Health Disparities and Inequalities Report-United States 2011; Rationale for Regular Reporting on Health Disparities and Inequalities-United States, MMWR 2011 (Suppl):3-10.

History

"The existence of a disability culture is a relatively new and contested idea. Not surprising, perhaps, for a group that has long been described with terms like 'in-valid,' 'impaired,' 'limited,' 'crippled,' and so forth. Scholars would be hard-pressed to discover terms of hope, endearment or ability associated with people with disabilities" (Brown 1994).

Disability culture is the catalyst to the foundation of occupational therapy and what is now the American Occupational Therapy Association because without disability, the occupational therapy profession would not exist. Critical to becoming culturally competent in practice is to not only view disability in a medical context of conditions we must treat, but also to embrace disability in a social context as another identifier and one of many cultures in itself.

"Similar to today, the United States faced many problems at the beginning of the 20th century, including war, immigration, industrialization, exploitation of workers, poor schools, and inadequate medical care. However, despite the daunting list of problems, the Progressive Era represented a time of great optimism and confidence in the idea that societal problems could be successfully addressed through progressive reforms. The *reformers* were people with strong views about democracy and social justice, and they held a firm belief in the power of science to influence proposed social, educational, and medical reforms." (Schwartz, 2009). Among these *reformers* were the founders of the occupational therapy profession, including but not limited to Eleanor Clarke Slagle and George E. Barton.

Eleanor Clarke Slagle was a leader in social reform and an advocate for individuals with disabilities working to ensure social justice and engagement in occupations. Slagle stated, "Covering a period of years of interest in the unfair social attitude toward the dependency of mentally and physically handicapped, followed by lectures on Social Economics by Professor Henderson, Chicago University, Jane Adams, Hull House, Julia Lathrop, now of the Children's Bureau…I took up [in] 1910 special courses in occupations and educational methods…" (Slagle,

n.d., p. 1). She helped lay the foundation of the occupational therapy profession to work to ensure inclusion of individuals with disabilities and their full participation in meaningful occupations.

"George Barton came to believe in the healing power of occupation through his own personal experience. In 1901, Barton learned he had tuberculosis. In 1912, he developed gangrene on his left foot while doing an environmental survey, and following surgery he developed hysterical paralysis on the left side of his body… Through his own journey of self-healing Barton learned the value of occupation. This experience led him to dedicate the rest of his life to helping others achieve the physical, emotional, and financial recovery that he had achieved" (Schwartz, 2009). An architect by trade, he worked to ensure that the environment was accessible and conducive to promoting healing and participation by those with disabilities or illness.

Occupational therapy's founders included advocates and individuals with disabilities who believed all people had a place in society. They were not only promoters of occupation, they were promoters of disability culture and helped pave the way, in a sense, for the disability rights movement and the growing recognition of disability culture today.

"Disability culture cannot be defined by one specific description or language. It is a complex blending of art, performance, expression, and community. Within this culture, the word 'disabled' has been re-purposed to represent a social identity of empowerment and awareness. Like many civil rights movements in the past, disability culture challenges the norms of society, and seeks to counter oppressive entities such as medicalization and institutionalization. Its core values as a culture are reflected in art, conversation, goals, or behaviors. These core values often include: "an acceptance of human differences, an acceptance of human vulnerability and interdependence, a tolerance for a lack of resolution of the unpredictable in life, and a humor to laugh at the oppressor or situation, however dire it may be" (Gill). Disability culture is unique in that it crosses all economic, age, gender, religious, race, and ethnic barriers. It encompasses many disabilities. No one is considered exempt from becoming disabled.

Disability culture also encompasses the disability rights movement. Like other civil rights movements, it took advocates from within and outside the culture to unite and advocate for societal change. As a result, key legislative was enacted to support the rights of individuals with disabilities. Today, the Rehabilitation Act of 1973, Fair Housing Act, Individuals with Disabilities Education Act, Ticket to Work & Workforce Investment Act, Air Carrier Act, Architectural Barrier Act, and Americans with Disabilities Act (ADA) play an integral role in creating opportunities and ensuring access and inclusion for individuals with disabilities in the U.S. and through the United Nations Convention on the Rights of People with Disabilities globally.

In 2015, we celebrate the 25th anniversary of the ADA. The US has come a long way, but still has so far to go before realizing the full intent of this legislation. The occupational therapy profession, much like other professions, continues to struggle with implementing this legislation. This is ironic as our profession began because of social injustice and the experience of one of the founders, who through therapeutic intervention, regained participation in occupation and became respected as a leader and contributing member of society.

Most health professionals are confident that their hospitals, institutions, and equipment are accessible. However, there is growing evidence that individuals with disabilities may receive inequitable care due to lack of accessible facilities, equipment, information and accommodations. The same holds true for students and professionals with disabilities, in that they do not have the same success or opportunities, and struggle to achieve career goals due to attitudinal and physical barriers.

To achieve competence in disability culture, individuals can explore a number of resources including but not limited to the culture itself, legislation, disability rights, resources on different disabilities, the arts, and publications specific to occupational therapy and disability. Engaging in disability culture, advocating, and ensuring that everyone can Live Life to Its Fullest, including students, occupational therapy professionals,

clients, and all individuals in our communities, is every occupational therapy practitioner's responsibility. It is what we are and what we do as a profession.

The following Internet resources, other publications and link to additional resources will help you begin your journey in understanding disability culture. The Network of Occupational Therapy Practitioners with Disabilities and Supporters (NOTPD) continues to build this Toolkit and are available to assist you. Please share your resources with us. We welcome you to join our network: http://www.notpd.org/join-notpd/

References

Brown, S. E. (1994). Investigating a culture of disability: Final report. Retrieved from http://dsq-sds.org/article/view/343/433

Schwartz, K. B. (2009). *Reclaiming our heritage: Connecting the founding vision* to the *Centennial Vision* [Eleanor Clarke Slagle lecture]. *American Journal of Occupational Therapy, 63,* 681–690.

Slagle, E. C. (n.d). *Experience of Eleanor Clarke Slagle*. Bethesda, MD: Wilma West Library Archives.

Gill, C. (1995). A psychological view of disability culture. *Disability Studies Quarterly*, 15(4), 16–19.

U.S. Census Bureau. (2012). Americans with disabilities 2010. Retrieved from http://www.census.gov/prod/2012pubs/p70-131.pdf

U.S. Department of Labor. http://www.dol.gov/odep/

General Internet Resources

ADA Anniversary Toolkit

ADA Technical Assistance & Other Resources

Disability Culture in NYC (arts)

Disability and Health (CDC)

Disability & Health Data System

Disability History Museum

Disability World (A web-zine of international disability news and views)

Films Involving Disabilities

Disability Social History Project:

Health and Health Care Disparities Among People with Disabilities

Independent Living Institute

National Centers for Health Statistics, Classifications of Diseases and Functioning & Disability
http://www.cdc.gov/nchs/about/otheract/icd9/icfhome.htm

Rehabilitation Research and Training Centers on Aging with a Disability Healthy Aging RRTC

Rehabilitation Research and Training Center on Developmental Disabilities and Health (RRTCDD)

Vaccine Protocols for Health Professionals. http://www.cdc.gov/flu/professionals/acip/2013-summary-recommendations.htm   and
http://www.hopkinsmedicine.org/mandatory_flu_vaccination/faq.html#Exceptions

Disability History: An Important Part of America's Heritages

Employment and TBI

VA database on PSTD and use the search term "employment"

Assistive Technology Industry Association including Friends of ATIA Newsletter and
Quality Indicators for Assistive Technology Listserv

Resources for Deaf or Hard of Hearing

Resources for Improving Health Care to Deaf and Hard of Hearing People is a project of the Centers for Medicare & Medicaid Services (CMS), Gallaudet University, and the Delmarva Foundation for Medical Care. This project provides resources for community members, professionals, and students. The Standards of Care for the Delivery of Mental Health Services to Deaf and Hard of Hearing Persons may be of particular interest.

The Gallaudet Research Institute (GRI) researchers gather and analyze data concerning the demographic and academic characteristics of deaf and hard of hearing populations, primarily to provide information needed by educators in the field.

Substance and Alcohol Intervention Services for the Deaf (SAISD), Rochester Institute of Technology, provides substance abuse recovery resources for consumers, their families and friends, and providers. SAISD offers a National Directory of Alcohol and Other Drugs Prevention and Treatment Programs Accessible to the Deaf.

National Association of the Deaf (NAD) is a membership organization with a mission "to promote, protect, and preserve the rights and quality of life of deaf and hard of hearing individuals in the United States of America." NAD has a position statement, Mental Health Services For People who are Deaf and Hard of Hearing, that may be of particular interest to Occupational therapy practitioners.

AOTA Publications

AOTA Fieldwork Information for OT Practitioners: Most Frequently Asked Questions, Education Special Interest Section Quarterly, August 2000.

Blanche, *EI Alma: coping with culture, poverty, and disability* AOTA (1996)

Hanebrink, S. and Wells, S. Guide to Reasonable Accommodation for OT Practitioners With Disabilities: Fieldwork to Employment. *AOTA (1998)*

Hanebrink, S. "Service Dogs: The Ultimate Assistive Technology**",** AOTA (2000 July 3) p.16-19

Hanebrink, S. **"**ADA consulting opportunities" AOTA (2000 Aug 28) p.12-15

Gitlow, L. *A study of occupational therapy faculty attitudes towards inclusion of students with disabilities in their educational programs* AOTA (1998)

Hanebrink, S**. "**Why Shut Out Practitioners With Disabilities" AOTA

Hanebrink, S**.** "Disabilities and the Real World" AOTA

Hanebrink, S**.** "A Double Standard?**"** AOTA

Hanebrink, S**.** "The Long Journey" AOTA

Hissong, AN. Occupational therapy's role with farmers with disabilities or disease AOTA (2008 Jul. 28)

Loukas, KM *Sports as occupation: a sports camp experience for children who are blind or have visual impairment* AOTA (2005)

Rosenbaum, RE *Sylvia's Story* AOTA (1995)

Stancliff, B.L. *"OT Student in Paralympics"* AOTA

Scott, S., Hartmann, K., Hanebrink, S. and Wells, S. *Educating College Students With Disabilities: What Academic & Fieldwork Educators Need to Know.* AOTA (1997)

Swinth, YL *Preparing students and therapists for culturally appropriate service delivery* AOTA (1995)

Tucker, TC. *Issues of Gay Men and Lesbians with Disabilities* AOTA (1995)

Journals

Cooper, RA *Awareness of disability culture in research* Andover Medical (1997)

Duncombe, LW *Cultural considerations in the development of children with disabilities: implications for future work potential* Andover Medical Publishers, Inc. (1997 Jul)

du Toit, S *Using the Model of Human Occupation to conceptualize an occupational therapy program for blind persons in South Africa* Informa Healthcare (2008)

Francisco, I *Occupational therapy and people with intellectual disability from culturally diverse backgrounds* Australian Association of Occupational Therapists, Inc, (2002)

Heard, CP *Disability culture online: Consumers informing occupational therapists: Overview of Disability Culture and Relevance to Occupational Therapy Practice* Canadian Association of Occupational Therapists (1999 Jul/Aug)

Kirshbaum, M *A disability culture perspective on early intervention with parents with physical or cognitive disabilities and their infants* Aspen Publishers, Inc. (2000 Oct)

Levasseur, M *Comparing the Disability Creation Process and International Classification of Functioning, Disability and Health models* Canadian Association of Occupational Therapists (2007)

Office of the United Nations High Commissioner for Human Rights   *The right to health* Centre for Human Rights (2008)

Pogrund, RL *Early focus: working with young children who are blind or visually impaired and their families* AFB Press (2002)

Rodriguez, MB *Cultural differences in response to adaptation to hand injury* Texas Woman's University (2001Dec)

Smith, DL *An occupational justice perspective of domestic violence against women with disabilities.* Association for the Journal of Occupational Science (2008 Oct.)

Susman, Joan "Disability, Stigma and Devience" Social Sciences and Medicine (1994)

Stucki, G *The International Classification of Functioning, Disability and Health (ICF): a unifying model for the conceptual description of the rehabilitation strategy* (2007 May)

[Additional Resources, Events and Publications are located on the NOTPD website](#) **(See NOTPD Toolkit Additional Resources)**

Occupational Therapy for Native Americans (OTNA)

Occupational Therapy for Native Americans (OTNA) was previously called the Network for Native American Practioners (NNAP). The number of Native American occupational therapists and occupational therapy assistants is extremely minimal. Because most of the occupational therapy practitioners providing services to Native people are not native themselves, the focus of our organization needed to change. Advocacy for this population needs to come from occupational therapy practitioners of all races, ethnicities, religions, sexual orientation, national origin, age, disabilities/abilities, gender, political beliefs, etc. There needs to be one voice, and that is the voice of humanity that advocates for equality in the provision of occupational therapy services and social justice so Native Americans with disabilities, can also live life to its fullest!

Mission & Purpose

The mission and purpose of OTNA is to advocate for Native Americans with disabilities, so that they can attain the highest quality of life possible through gaining physical, psychological, and spiritual independence. Advocacy can take many forms, such as education, knowledge of resources, development of resources, cultural competence development, and mentoring.

Objectives

1. To advance an understanding of the unique cultural needs of Native Americans.

2. To advocate for Native Americans with disabilities.
3. To provide a venue where occupational therapy practitioners can learn more about the Native American culture so they can provide culturally competent services.
4. To serve as a place to network.
5. To recruit and retain Native Americans into the profession of occupational therapy.
6. To develop and share resources.

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http://www.otnna.com/

Demographics

The Native American and Alaska Native ethnic groups were established long before Europeans settled in North America. Many individuals know a nominal amount of the history of this diverse ethnic group, as many died from disease and were killed once the Europeans settlers arrived in North America. Their history has been difficult to preserve due to death, slavery, and inequality since the European settlement. They were once the largest ethnic groups in North America of people having origins in North, South, and Central America, yet they are now the smallest.

In 2012, collectively, this ethnic group represented 2% of the U.S population. It is estimated that out of the 318.9 million Americans, 5.2 million people were classified as American Indian and Alaska Native alone or American Indian and Alaska Native in combination with one or more other race (Centers for Disease Control and Prevention, n.d.).

Of these 5.2 million, 22% of American Indians and Alaska Natives live on reservations or other trust lands, and 60%live in metropolitan areas. There are 566 federally recognized American Indian and Alaska Native tribes, and more than 100 state-recognized tribes. There are also tribes that are not state or federally recognized.

In the 2010 U.S. Census, tribal groupings with 100,000 or more responses were:

Cherokee (819,105)

Navajo (332,129)

Choctaw (195,764)

Mexican American Indian (175,494)

Chippewa (170,742)

Sioux (170,110)

Apache (111,810)

Blackfeet (105,304) (Centers for Disease Control and Prevention [CDC], n.d.). In 2013, there were 14 states with more than 100,000 American Indian and Alaska Native residents: California, Oklahoma, Arizona, Texas, New Mexico, Washington, New York, North Carolina, Florida, Alaska, Michigan, Oregon, Colorado and Minnesota (Centers for Disease Control and Prevention, n.d.).

In 2013, the states with the highest percentage of American Indian and Alaska Native population were:

Alaska (14.3%)

Montana (6.8%)

New Mexico (9.1%)

Oklahoma (7.5%)

South Dakota (8.5%) (U.S Department of Health and Human Services [HHS], Office of Minority Health, 2015).

Language

In 2012, 20% of American Indians/Alaska Natives spoke a language other than English at home (HHS, 2015).

Education

As of 2012, 82% of the estimated 5.2 million American Indians and Alaska Natives, age 25 and over, had at least a high school diploma; 17% had at least a bachelor's degree; and 6% had at least an advanced graduate degree (i.e., master's, PhD, medical, or law) (HHS, 2015).

Economics

The median household income for American Indians and Alaska Natives is $37,353, and 29% age 16 and over work in management and professional occupations. Despite 82% having high school diplomas, 26% of these ethnic groups live at the poverty level (HHS, 2015).

Insurance Coverage

 The percentage of American Indians and Alaska Natives who lacked health insurance in 2014 was 26.9%, of the 5.2 million Native American in the United States of America.(Centers for Disease Control and Prevention, n.d.).

Health

American Indians and Alaska Natives frequently contend with issues that prevent them from receiving quality medical care. These issues include cultural barriers, geographic isolation, inadequate sewage disposal, and low income.

The top 10 leading diseases and causes of death among American Indians and Alaska Natives are:

1. Cancer
2. Heart Disease
3. Unintentional Injuries
4. Diabetes
5. Chronic Liver Disease & Cirrhosis
6. Chronic Lower Respiratory Diseases

7. Stroke

8. Suicide

9. Nephritis, Nephrotic Syndrome & Nephrosis

10. Influenza & Pneumonia (CDC, n.d.)

Religion

Native American religion is complex and difficult to explain, because many tribes passed down their religious principles verbally. Although the beliefs were similar, many tribes practiced their own religion. The religious aspects of this ethnic group normallyfocuses around nature: landscape, animals, plants, and other elements of the environment. . This also consists of several practices, ceremonies, and traditions. These ceremonies may honor of a number of events such as celebrating feasts, music, dances, and other performances (Indians.org, n.d.).

Internet Resources

1. National Library of Medicine: Health Care to Native Americans

2. Medline Plus: Native American Health

   - Genetics

   - Environmental factors

   - Access to care

   - Cultural factors

4. Bureau of Indian Affairs (BIA)

   Even though the BIA website has been essentially shut down for the last several years, they have a comprehensive list of related links. This is the link for the U.S. Department of the Interior Indian Affairs: http://www.bia.gov/

5. U.S. Department of Health & Human Services: Indian Health Services

   The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 556 federally recognized tribes in 35 states.

6. Register of Federally Recognized Tribes

   Dated July 12, 2002, list of 562 tribal entities recognized and eligible for funding and services form the Bureau of Indian Affairs by virtue of their status as Indian tribes.

7. National Library of Medicine, American Indian Health Search An information portal to issues affecting the health and well-being of American Indians.

8. National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR), University of Colorado Health Sciences Center

   The NCAIANMHR is one of four minority mental health research Centers

sponsored by the National Institute of Mental Health and is the only program of this type in the country focusing specifically on American Indian and Alaska Native populations

10. [National Indian Child Welfare Association (NICWA)](#)

    NICWA is dedicated to the well-being of American Indian children and families. The partnership with the Center for Mental Health Services and an interagency agreement with the Indian Health Service (IHS) allows NICWA to provide technical assistance to seven tribal service grantees and nine "Circles of Care" planning grantees.

11. [SACNAS (The Society for Advancement of Chicanos and Native Americans in Science)](#)

    SACNAS is a diverse society with a vested interest in promoting opportunities in graduate science education for Chicano/Latino, Native American, and other students.

Videos

1. HBO Films original production 'Bury My Heart At Wounded Knee' ... Bury My Heart At Wounded Knee DVD.
2. PBS: Indian Country Diaries
3. PBS: Way of the Warrior
4. NATIVE AMERICANS - A TRIBUTE (2008)
5. 'Two Rivers' - A Native American Reconciliation (2007)
6. Dream Keeper (2004)
7. The Trail of Tears: Cherokee Legacy (2006)
8. Bury My Heart at Wounded Knee (2007)
9. How To Trace Your Native American Heritage (2003)
10. Native American Medicine (2002)
11. History - Wild West Tech : Native American Tech (2008)

References

Centers for Disease Control and Prevention. (n.d.). American Indian and Alaska Native populations. Retrieved from
http://www.cdc.gov/minorityhealth/populations/REMP/aian.html

Indians.org. (n.d.). Native American religion. Retrieved from
http://www.indians.org/articles/native-american-religion.html

U.S. Department of Health and Human Services, Office of Minority Health. (2015). Profile: American Indian/Alaska Native. Retrieved from
http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlID=62

Orthodox Jewish Occupational Therapy Chavrusa (OJOTC)

The mission

The OJOTC was formed to provide a forum for Jewish OT practitioners and students to network.

The goals

- To work with our professional organizations in meeting the religious needs of our members
- To provide a forum for our members and other occupational therapists to discuss issues related to practice and our religion
- To educate practitioners about the cultural needs of their Jewish clients
- To assist our members in resolving conflicts that may arise including Shabbat, Kashrut and other religious commitments

Contacts

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Web site: www.ojotc.org

Resources

In keeping with the mission and goals of the Orthodox Jewish Occupational Therapy Caucus the resources on this page of the Toolkit are different - as reflective of the needs this group represents.

The following are three areas of how orthodoxy impacts the life of the Orthodox observant Jew. It is anticipated that this information will better enable cultural sensitivity and awareness of the occupational therapy practitioner for both clients and peers.

I. Kosher

Often referred to as "keeping kosher", the rules and details of this religious observance are complex and beyond the scope of this toolbox. Rather, the focus of this section is to better enable non-orthodox individuals to appreciate the practical impact for clients and clinician.

According to Orthodox Jewry ALL food consumed must be kosher. This status is determined differently for different categories of food, but is established by a "kosher symbol" that identifies the

food item as kosher. Some of the more widely recognized symbols include: among many others.

Food that is not kosher, or food that is kosher but opened without orthodox supervision, or food that is placed in a non-kosher receptacle (i.e., serving bowl) cannot be consumed by an orthodox Jewish person. This may create difficulties in in-patient settings, out-patient cooking/meal preparation activities and/or community based treatment settings. In addition, meat and dairy food items cannot be consumed at the same meal, on the same eating surface, or with the same utensils.

Awareness of this requirement opens lines of communication and enables practitioners to help their clients in meaningful ways.

II. Sabbath/Shabbos/Shabbat and Holidays

Every week from sunset Friday through sundown Saturday orthodox Jews observe the Sabbath (pronounced differently dependent on region). This twenty-six hour observation involves prayers, meals and family time. The most significant aspect to understand for the purposes of this tool box is

that no "work" can be done during its duration. "Work" is defined as energy creating activities so that using electricity (i.e., opening lights), transportation other than walking (i.e., car), and talking on the telephone are all prohibited.

These restrictions apply to specific holidays on the Jewish calendar including the High Holidays and Passover to name a few. Orthodox Jews take these restrictions very seriously and very literally. While these restrictions do not apply if a life is at stake, observing as much of these religiously significant behaviors and restrictions is a value that should be respected.

Awareness of this area of observance will help clinicians develop sensitivity to both patients and their families. Respect of their clients' values for these observances will put clinicians in the unique position to provide support. In addition, better understanding of these restrictions will help clinicians understand the needs of their peers. The OJOTC, as a member of the MDI Network, is available to provide support to clinicians in meeting the needs of diverse clients.

III Gender Issues

This is not the place for a theological discussion related to gender roles and religion. Rather this is a brief presentation of the practical impact of gender issues that may impact practice.

The primary concept to remain aware of is that there is a general restriction for individuals to limit physical contact to close relatives of the opposite sex and avoid such contact with non-relatives. Therefore, shaking hands or other casual contact between individuals of opposite sex is not acceptable. This impacts introductions and casual interactions but does not limit treatment techniques. Touch for the sake of healing, which occupational therapy practitioners use regularly, is acceptable – and encouraged. Life, and the quality of life, is a value. Therefore, treatment is not restricted to same gender practitioners, though it is preferred. It is helpful to keep in mind that orthodox Jews do not have experience with casual touching and are often uncomfortable with touch, without indicating dysfunction. A clinician discussing sexual dysfunction with a client anticipates a certain amount of discomfort and addresses the issue respectfully. All touch with an orthodox person of an opposite sex to the practitioner should be understood in this context. In addition, keep in mind that this applies to family members as well. Lastly, eye contact discomfort with persons of the opposite sex exists in some segments of orthodoxy and should be tolerated and not perceived as rudeness.

Awareness of this area of observance will enable clinicians to avoid creating embarrassing or awkward moments with clients, client families, and peers.

Additional Resources

There are no websites the OJOTC endorses for better understanding of Judaism. We are available to answer questions and help practitioners with specific cases and can be reached by the contact information listed above.

There are websites related to Jewish resources for persons with disabilities, recommendations for specific clients' needs can be attained by contacting the OJOTC.

Recommendations for specific clients' needs on these, or other issues, can be attained by contacting the OJOTC at: www.OJOTC.org

Terapia Ocupacional para Diversidad, Oportunidad y Solidaridad (TODOS)

Network of Hispanic Providers

Mission

TODOS is a network and a professional community of occupational therapy practitioners and students who have as their mission to support and mentor one another; to support the exploration of careers in occupational therapy by Hispanics/Latinos; and to promote issues of diversity, inclusion, and multiculturalism within the occupational therapy Profession.

The purpose of TODOS is to:

- Provide a consistent voice to AOTA, and state and local professional organizations regarding the needs and concerns of Hispanic/Latino practitioners, students, and consumers
- Support and mentor one another, and promote Hispanics/Latino representation and leadership in local, state, and national decision-making bodies
- Promote the exploration of careers in occupational therapy by Hispanics/Latinos
- Support Hispanic/Latino practitioners who immigrate from other countries, through the process of adjustment and transition into the occupational therapy profession in the USA.

TODOS website http://todosinusa.weebly.com

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Key Facts

The Hispanic (Spanish speaking) population in the United States has experienced considerable growth and has become the largest minority group, representing 17.1% of the population (U.S. Census Bureau, 2011). The Hispanic population migrating to the United States faces multiple challenges, with language proficiency and health literacy among the most common. These deficiencies result in socioeconomic disadvantages related to high poverty levels and limited access to health care services. The economic, social, and psychological burdens imposed by poor health on populations that are already disadvantaged can be particularly devastating (Kington & Nickens, 2001).

Language Proficiency

An article in the *AMA Journal of Ethics* (Volandes & Paasche-Orlow, 2007) presented this conceptual suggestion: Should all U.S. physicians speak Spanish? Even though the role of the physician is to direct and provide medical care to individuals, inadequate communication contributes heavily to disparities in health care quality (National Academies Press, 2002), and language concordance between patients and physicians has been shown to reduce the overall costs to hospitals (Jacobs, Sadowski, & Rathouz, 2007). The article makes the case that it would be in the best interests of physicians to learn Spanish in order to facilitate health learning and promote healthier habits in individuals. Furthermore, there are fewer physicians than Spanish-speaking individuals, with a ratio of physicians to patients who speak English less than "very well" of approximately 22:1 (U.S. Census Bureau 2011; U.S. Department of Labor, 2012).

Similarly, these language attributes could be generalized to occupational therapy practitioners in the United States. The AOTA Centennial Vision calls for occupational therapy to become a profession that is globally connected, with a diverse workforce that meet society's occupational needs (AOTA, 2007). On August 11, 2000, then- President Bill Clinton signed executive order 13166, "Improving access to Services for Persons with Limited English Proficiency (LEP) (see [http://lep.gov). Yet clearly there is still a broadly recognized need for better communication in health care.](http://lep.gov)

There are several tools available to occupational therapists to communicate with Spanish-speaking individuals:

1) Interpreters—This option will ensure the most accurate translation and facilitate discussions with clients.
    a. The National Standards for Interpreters in Health Care is a reference for interpreters and those who employ them.
    b. The National Council on Interpreting in Health Care is a multidisciplinary organization whose mission is to promote and enhance language access across the U.S.
    c. The Cross Cultural Health Care Program serves as a bridge between communities to advance access to health care that is culturally and linguistically appropriate.
2) Language Applications—These should be used with caution, because literal translations from available apps may not accurately convey information, due to changes in connotations and denotations of words and phrases. Apple and Android offer a variety of apps to assist with communication and translation
    a. Google Translate: Free
    b. Itranslate: Free
    c. Ispeech Translator: Free
    d. Occupational Therapy Spanish Guide by Mavro: Free or Upgrade for $
3) Courses/Books—Jacqueline Thrash, OTR, has published *Common Phrase Translation: Spanish for English Speakers for Occupational Therapy, Physical Therapy, and Speech Therapy*.

Health Disparities and Access to Health Services

According to a report of the National Research Council, without good health an individual may not be able to experience, participate in, and enjoy different dimensions of life such as the ability to learn, attend school, work, be steadily employed, participate in social activities, be part of a community, have a sense of belonging and well-being, and engage in relationships. Hispanics have lower age-adjusted mortality rate despite disparities in employment, education, and level of poverty (National Research Council, 2002).

- Emerging Issues in Hispanic Health: Summary of a Workshop.
- Latino Health Disparities Compared to non-Hispanic Whites
- Examples of Health Disparities, Hispanic or Latino Populations, by the CDC
- American Psychiatric Association Fact Sheet: Mental Health Disparities: Hispanics/Latinos

References

American Occupational Therapy Association. (2007). AOTA's Centennial Vision and Executive summary. *American Journal of Occupational Therapy, 61*, 613–614.

Jacobs E. A., Sadowski, L. S., & Rathouz, P. J. (2007). The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *Journal of General Internal Medicine, 22*(Suppl. 2), 306–311.

Kington, R. S., & Nickens, H. W. (2001). Racial and ethnic differences in health: Recent trends, current patterns, future directions. In N. J. Smelser, W. J. Wilson, & F. Mitchell (Eds.), *America becoming: Racial trends and their consequences II* (pp. 253–310). Washington, DC: National Academy Press.

National Academies Press. (2002). Front matter . *Guidance for the National Healthcare Disparities Report*. Washington, DC: Author .

National Research Council. (2002). Emerging issues in Hispanic health: Summary of a Workshop. In Joah G. Iannotta (Ed.), *Committee on Population, Division of Behavioral and Social Sciences and Education* (pp. 1–8). Washington, DC: National Academies Press.

U.S. Census Bureau. (2011). Language use. Retrieved from http://www.census.gov/population/www/socdemo/lang_use.html.

U.S. Department of Labor, Bureau of Labor Statistics. (2012). *Occupational outlook handbook*. Retrieved from http://www.bls.gov/cps/cpsrace2011.pdf

Volandes, A. E., & Paasche-Orlow, M. K. (2007). Health literacy, health inequality and a just healthcare system. *American Journal of Bioethics* 7(11), 5–10.