Perceived Levels of Cultural Competence Among Occupational Therapists

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KEY WORDS
• cultural competency
• culture
• occupational therapy
• professional competence

Occupational therapists confront issues of cultural diversity more than ever before because of the increased number of clients seen in their professional practice who are of differing racial or cultural backgrounds. In this study, we examine perceived cultural competence in a sample of 477 occupational therapists. The study’s results indicate that among the variables that most affected how therapists rate their level of cultural competence were prior training and favorable attitudes toward cultural competence. Prior training, both formal and informal, was positively correlated with higher levels of cultural competence. In addition, practitioners who placed more value on cultural competence and felt more culturally competent to address the needs of diverse clients scored higher across all of the dimensions of cultural competence measured. These dimensions included cultural awareness and knowledge, cultural skills, and organizational support for multicultural practice. The results have implications for teaching, research, and practice in occupational therapy.


More than ever before, practitioners from a variety of fields are considering issues of race, ethnicity, and cultural competence in their practice. This interest reflects the fact that the United States is becoming increasingly diverse. The 2000 census figures suggest that about 30% of the total U.S. population is of non-European White background and that people of color are becoming numerical majorities in some of our largest cities (U.S. Census Bureau, 2000). Moreover, evidence has suggested significantly higher rates of health disparities and disability among people of color (Brach & Fraser, 2000; Fiscella, Franks, Gold, & Clancy, 2000). Given these trends, health professionals, such as occupational therapists, are more likely than ever to encounter individuals from diverse ethnic backgrounds in their practices and yet may not necessarily feel the need or be prepared to adapt their practices to the specific cultural values and needs of these diverse groups of clients. In fact, previous research has suggested that African-American and Latino clients are not achieving the same positive outcomes in rehabilitation and independent living as are White clients (Olney & Kennedy, 2002; Wilson, 2002; Wilson, Harley, & Alston, 2001). These are compelling reasons for researchers and professionals to study cultural competence in the context of occupational therapy as an additional core skill necessary for effective practice.

The U.S. Department of Health and Human Services’ Office of Minority Health has produced new recommended standards for cultural competence in health care (Black & Wells, 2007). An important change refers to the increasing demand for clinicians to practice from a client-centered perspective that involves matching practice to the client’s ethnic, racial, or cultural context. Another recommendation refers to treating patients in a variety of nontraditional contexts, such
as in community-based organizations and health centers rather than the traditional hospital setting. Occupational therapists are more likely to work with patients who have not only differing beliefs, values, attitudes, and behaviors but also different definitions of the nature of work, leisure, health, and self-care (Black & Wells, 2007). With the occupational therapy client population becoming increasingly diverse, a culturally competent practitioner is essential (Suarez-Balcazar & Rodakowski, 2007).

A growing body of literature is available on the topic of cultural competence in the fields of psychology (e.g., Cross, Bazron, Dennis, & Isaacs, 1989; Sue, Arredondo, & McDavis, 1992), nursing (e.g., Campinha-Bacote, 2001; Leninger, 2000; Purnell & Paulanka, 2002), and other health professions (e.g., Black & Wells, 2007; Bonder, Martin, & Miracle, 2004; Wells & Black, 2000). This body of literature contains a variety of opinions about how cultural competence should be defined (Bonder et al., 2004). However, one of the most commonly accepted definitions of cultural competence in health care was developed by Campinha-Bacote (1999) in the nursing profession. According to this definition, cultural competence is demonstrated when the practitioner understands and appreciates differences in health beliefs and behaviors, recognizes and respects variations that occur within cultural groups, and is able to adjust his or her practice to provide effective interventions for people from various cultures.

As noted by Black and Wells (2007), a few conceptual practice models in the field of occupational therapy have begun to address the cultural aspect of occupations. In 1973, Lela A. Llorens commented on the association she felt regarding furthering her knowledge of culture and the improved relationship with her patients. The first model to acknowledge the impact of culture on occupational choice was the Model of Human Occupation (Kielhofner & Burke, 1980). Since that time, other emerging conceptual practice models have acknowledged culture as an aspect that affects occupational choice (e.g., Christiansen & Baum, 1997; Dunn, Brown, & McGuigan, 1994; Law et al., 1996; Schkade & Schultz, 2003). Furthermore, others have contributed to this literature with a set of guidelines for culturally competent occupational therapy (e.g., Dillard et al., 1992), recommendations, and two comprehensive books on the topic (Black & Wells, 2007; Wells & Black, 2000).

The Culture Emergent Model (Bonder et al., 2004), which comes from the occupational therapy literature, recognizes that culture is learned, localized, patterned, evaluative, and persistent, although it also incorporates change. The combination of these factors can allow health care practitioners, specifically occupational therapists, to acknowledge the aspects that make up culture and influence the clients with whom they work.

Suarez-Balcazar, Muñoz, and Fisher (2006) suggested that culturally responsive occupational therapy practice is attentive to a broad knowledge base that helps occupational therapists understand the worldviews of people living in diverse ethnic, racial, and cultural communities. From an occupational therapy perspective, Suarez-Balcazar and Rodakowski (2007, p. 15) asserted that “becoming culturally competent is an on-going contextual, developmental, and experiential process of personal growth that results in professional understanding and ability to adequately serve individuals who look, think, and behave differently from us.” This process of becoming culturally competent can happen through repetitive engagements with diverse groups, by increasing one’s critical awareness and knowledge, and by having opportunities for reflection and analysis of professional performance. Cheung, Shah, and Muncer (2002) reported a study assessing perceptions of cultural competence among occupational therapy students. They found that the majority of students reported having limited awareness of and exposure to other cultures and insufficient training in cultural competence.

One shortcoming in the current cultural competence research literature is the limited number of validated measures available to assess cultural competence. Balcazar, Suarez-Balcazar, Willis, and Alvarado (in press) analyzed 18 published models of cultural competence and found four key components that cut across most identified models: (1) cultural awareness, (2) cultural knowledge, (3) cultural skills, and (4) practice and application of cultural competence. They also found 14 scales that measure cultural competence, with 10 providing some type of validity or reliability measure. The most commonly used scales include those of Campinha-Bacote (2003); LaFromboise, Coleman, and Hernandez (1991); and Sodowsky (1996). However, none of these scales has been used with occupational therapists; in fact, the available scales have mostly been developed and validated in the fields of nursing and counseling psychology.

Suarez-Balcazar et al. (2008) developed and validated the Cultural Competence Assessment Instrument (CCAI) with occupational therapists and confirmed the importance of two of the four cross-cutting components of cultural competence identified by Balcazar et al. (in press). The resulting components from the factor analysis were cultural awareness and knowledge, cultural skills, and organizational support for multicultural practice (Balcazar, Suarez-Balcazar, & Taylor-Ritzler, 2009).

Our purpose in this study was to assess the perceived levels of cultural competence from a representative random sample of occupational therapists using the CCAI instrument developed and validated by Suarez-Balcazar et al. (2008). In addition, we sought to examine the relationships
between perceived cultural competence and the following variables: age, years of practice, working with ethnically and racially diverse clients, prior cultural competence training, and attitudes toward cultural competence.

Method

Sample Selection and Procedure

A total of 1,000 names was randomly generated from the American Occupational Therapy Association's (AOTA's) list of current registered occupational therapists. Those selected received by mail a cover letter describing the purpose of the study; a copy of the survey; a stamped, self-addressed return envelope; and a $1 bill as an incentive to participate. We did not send follow-up reminders to potential respondents. A total of 477 practitioners participated in the study for a 47.7% response rate. All surveys were received within 3 months.

Survey Instrument

The original CCAI sent to occupational therapists included 49 items that measured four components: awareness, knowledge, skills, and practice and application of cultural competence. A detailed description of the development and validation of the CCAI, including psychometric data, can be found in Suarez-Balcazar et al. (2008). A factor analysis confirmed the presence of two of the four components and yielded a 24-item survey designed to assess Cultural Awareness–Knowledge (eight items; Cronbach's $\alpha = .76$); Cultural Skills (eight items; Cronbach's $\alpha = .82$); and a new factor, Organizational Support for Multicultural Practice (eight items; Cronbach's $\alpha = .80$). All CCAI survey questions were rated on a 4-point scale ranging from 4 (strongly agree) to 1 (strongly disagree). This analysis focused on the instrument that resulted from the factor analysis.

Within the CCAI, cultural awareness–knowledge refers to the appreciation and understanding of other people’s cultures and acknowledgment of one’s biases toward other cultures. Examples of Cultural Awareness–Knowledge subscale items are “It is difficult to accept that religious beliefs may influence how multicultural populations respond to illness and disability,” “I feel confident that I can learn about my clients' cultural background,” and “I examine my own biases related to race and culture that may influence my behaviors as a health provider.” The Cultural Skills subscale assesses the degree to which one possesses the necessary ability to adjust practice to service the needs of multicultural populations. Examples of Cultural Skills items include “I am effective in my verbal communication with clients whose culture is different from mine,” “I openly discuss with others issues I may have in developing multicultural awareness,” and “I have the opportunity to learn culturally responsive behaviors from peers.” Finally, Organizational Support for Multicultural Practice assesses the perceived institutional or work setting value placed on the consideration of others’ cultures and the contextual opportunities to become culturally competent. Examples of Organizational Support for Multicultural Practice items include “I receive feedback from supervisors on how to improve my practice skills with clients from different ethnic minority backgrounds,” “My workplace does not support my participation in cultural celebration of my clients,” and “Cultural competence is included in my workplace’s mission statement, policies, and procedures.”

We also included a demographic section in the survey to gather information on gender, education, current work setting, years of practice, self-report of attitudes toward working with various cultures and various types of disabilities, and previous experience with cultural competence training (both formal and informal).

Results

Descriptive Analysis

Demographics. The vast majority of survey respondents were female (94%) with a mean age of 43.3 years (standard deviation [SD] = 10.43, range = 23 to 69). Most respondents identified themselves as White (91%). The remaining 9% identified with one or more racial or ethnic minority group. In terms of educational degrees obtained, 53% of the respondents had an occupational therapy bachelor’s degree, 45% had an occupational therapy master’s degree, and 2% had either a PhD or another doctoral degree. Respondents indicated the following primary practice settings: 25% practiced in schools, 14% in nursing homes, another 14% in rehabilitation facilities, 9% in individual home care, 8% in private practice, 6.4% in patient hospital care, 5.5% in outpatient hospital care, and 4% in community-based practice. Fourteen percent of the respondents reported other practice settings or no current practice setting. The remaining 0.1% did not respond.

Years of professional practice and experience working with multicultural populations. Study participants reported a wide range of years of practice, ranging from 1 year to 53 years ($mean [M] = 17.32, SD = 10.64$). Listed on the survey were six categories of racial and ethnic groups that occupational therapists potentially see in practice: (1) African-American–Black; (2) Asian (Chinese, Japanese, Korean, Indian, Arab, and Other); (3) Pacific Islander; (4) American Indian–Native American; (5) Hispanic–Latino; and (6) and White, European,
non-Hispanic. Participants were asked to check off all groups they worked with. Participants most commonly reported working with individuals from four racial and ethnic groups: About 96% reported working with Whites, 72% worked with African-Americans, 69% worked with Hispanics, and 37% worked with Asians.

Prior cultural competence training. Thirteen percent of respondents reported no prior cultural competence training. Of those who reported a training activity, 15.7% took a required class on cultural competence, 4.4% took an elective course, 46% indicated that the topic of cultural competence was covered in various courses in occupational therapy school, 28.9% learned about cultural competence during fieldwork, 19.9% took continuing education workshops or courses on cultural competence, 38% gained knowledge through readings on the topic, 28% learned cultural competence from supervision on the job, and 58.3% indicated that they gained knowledge by interacting with professionals from other disciplines at their workplace. More than half of the respondents reported more than one type of training on cultural competency. The mean number of training experiences reported was 2.39 (median = 2; SD = 1.65).

Attitudes toward cultural competence. When asked about the importance that respondents placed on being culturally competent and how culturally competent they felt to address the needs of diverse populations, 78.4% of the respondents agreed or strongly agreed that being culturally competent is one of the most important skills in their practice, and 82.5% agreed or strongly agreed that they felt equipped to address the specific needs of individuals from different groups.

Perceived levels of cultural competence across all three dimensions. In general, most respondents scored fairly high on all three dimensions of cultural competence measured by the CCAI. On the 4-point rating scale (on which the higher the score was, the higher the attribute was), the statistical means obtained for each dimension were 3.25 (SD = 0.35) for Cultural Awareness–Knowledge, 3.08 for Cultural Skills (SD = 0.39), and 2.88 for Organizational Support for Multicultural Practice (SD = 0.47). Further results revealed that all three dimensions were positively correlated with each other. Table 1 displays the correlations among all three dimensions.

Inferential Analysis

Respondents’ age. To assess differences across all three cultural competence subscales on the basis of age, we formed two main groups: Respondents who were ages ≤40 made up the first group (39.2%), and respondents who were ages ≥41 made up the second group (60.8%). Pearson product–moment correlations showed that respondent age was not statistically associated with two of the three dimensions of cultural competence (Cultural Awareness–Knowledge, \( r = .20, p < .01 \); Cultural Skills, \( r = .09, p = .09 \); and Organizational Support for Multicultural Practice, \( r = .08, p = .18 \)). Cultural Awareness–Knowledge was the only subscale that yielded a statistically significant difference between the two age groups, with older respondents scoring higher than younger respondents (\( F[1, 257] = 12.29, p < .01 \)). This result indicates that respondents who were between ages 41 and 60 exhibited a higher appreciation and understanding of other people’s cultures and acknowledgment of one’s biases toward other cultures more often than did respondents ages ≤40.

Years of professional practice and past training. Study participants reported a wide range of years of practice, from 1 year to 53 years (\( M = 17.32, SD = 10.64 \)). On the basis of the responses obtained, we formed three groups for comparison purposes: respondents with 1 to 10 years of practice (33.8%), respondents with 11 to 20 years of practice (26.5%), and respondents with >20 years of practice (39.7%). As occurred with the age variable, we detected no statistical differences among the three practice groups on any of the three dimensions of cultural competence. More specifically, those with more years of practice (11 to 20 and >20) had higher scores than those with ≤10 years of practice (\( M_s = 3.30, 3.30, \) and 3.17, and \( SDs = 0.35, 0.33, \) and 0.34, respectively). No differences were observed between respondents with 11 to 20 years of practice and respondents with >20 years of practice. Cultural Awareness–Knowledge was positively correlated with years of professional practice (\( r = .16, p < .01 \)).

Working with ethnically and racially diverse clients. No statistically significant differences existed between those practitioners who worked with Hispanics and those who did not on any of the three dimensions of cultural competence (Cultural Awareness–Knowledge, \( F[1, 330] = 0.14, p = .71 \); Cultural Skills, \( F[1, 407] = 0.23, p = .63 \); and Organizational Support for Multicultural Practice, \( F[1, 281] = 0.13, p = .71 \)). We found similar results between practitioners working with Asians and practitioners not working with this population (Cultural Awareness–Knowledge, \( F[1, 330] = 0.94, p = .33 \); Cultural Skills, \( F[1, 407] = 0.39, p = .54 \); and Organizational Support for Multicultural Practice,

<table>
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<tr>
<td>1. Cultural Awareness–Knowledge</td>
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<td>2. Cultural Skills</td>
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<tr>
<td>3. Organizational Support for Multicultural Practice</td>
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Note. All ps significant at .01.
However, three separate analyses of variance (ANOVAs) showed that practitioners who reported working with African-Americans differed significantly from those who reported not working with African-Americans on one of the three cultural competence dimensions: Cultural Skills ($F[1, 407] = 4.57, p < .05$). No statistically significant results emerged for Cultural Awareness–Knowledge ($F[1, 330] = 0.05, p = .82$) and Organizational Support for Multicultural Practice ($F[1, 281] = 0.55, p = .46$).

Interestingly, practitioners who reported not working with White clients at all had significantly higher scores on two of the three subscales: Cultural Awareness–Knowledge ($F[1, 330] = 4.05, p < .05$) and Cultural Skills ($F[1, 407] = 6.62, p < .05$). No statistically significant results emerged for Organizational Support for Multicultural Practice ($F[1, 281] = 0.01, p = .91$).

**Prior cultural competence training.** On the basis of the aggregated number of prior training or activities related to cultural competence, prior exposure to cultural training was positively correlated with all three dimensions measured by the CCAI: Cultural Awareness–Knowledge ($r = .18$), Cultural Skills ($r = .17$), and Organizational Support for Multicultural Practice ($r = .23$; all correlations were statistically significant at $p < .01$).

**Attitudes toward cultural competence.** Respondents who considered being culturally competent an important skill in their profession scored higher across all three subscales compared with those who placed less importance on such skill. Three separate ANOVAs revealed that all differences were statistically significant at $p < .01$ (Cultural Awareness–Knowledge, $F[1, 326] = 15.41$; Cultural Skills, $F[1, 406] = 8.67$; and Organizational Support for Multicultural Practice, $F[1, 277] = 11.26$). Table 2 displays the means and standard deviations for all three subscales by level of agreement with the importance of cultural competence.

**Perception of cultural competency.** Respondents who felt culturally competent to address the variety of needs of clients from different cultural backgrounds obtained higher scores across all three subscales compared with those who felt less competent. Three separate ANOVAs showed that all differences were statistically significant at $p < .01$ (Cultural Awareness–Knowledge, $F[1, 328] = 30.47$; Cultural Skills, $F[1, 409] = 84.56$; and Organizational Support for Multicultural Practice, $F[1, 279] = 34.22$). Table 3 includes the means and standard deviations for all three subscales by perception of cultural competency.

**Discussion**

Our sample of occupational therapists scored relatively high on all three dimensions of cultural competence. Interestingly, we found that older therapists (between ages 41 and 60) and those with more years of practice scored significantly higher in Cultural Awareness–Knowledge. Similarly, therapists with more training, both formal and informal, rated themselves higher in perceived levels of cultural competence than did those with less training. These findings indicate that perhaps older therapists with more practice experience might have had more exposure to a variety of opportunities to learn from multicultural populations and might have seen a wider variety of clients in practice. Other researchers have also found that experience and practice affect cultural competence in health professionals (Leninger, 2000; Sodowsky, 1996). However, no research study has found that age was a factor in itself. More research needs to be conducted to examine the relationship among age, years of practice, and training opportunities.

Practitioners who reported working with African-American clients differed significantly in cultural competence skills from those who reported serving Hispanics, Asians, Whites, or a mix of these groups. This interesting finding might suggest that clinicians working with African-Americans are exposed to situations that require the development and practice of multicultural skills that are different.

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**Table 2. Respondents’ Responses to the Statement “Being Culturally Competent Is One of the Most Important Skills in My Professional Practice”**

<table>
<thead>
<tr>
<th>Cultural Competence Dimension</th>
<th>Respondents’ Attitude</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Cultural Awareness–Knowledge</td>
<td>3.08</td>
<td>0.36</td>
</tr>
<tr>
<td>Cultural Skills</td>
<td>2.97</td>
<td>0.42</td>
</tr>
<tr>
<td>Organizational Support for Multicultural Practice</td>
<td>2.69</td>
<td>0.39</td>
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*Note. SD = standard deviation.*

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**Table 3. Respondents’ Responses to the Statement “I Feel Culturally Competent to Address the Needs of Individuals From Different Cultural Groups”**

<table>
<thead>
<tr>
<th>Cultural Competence Dimension</th>
<th>Respondents’ Attitude</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Cultural Awareness–Knowledge</td>
<td>3.03</td>
<td>0.26</td>
</tr>
<tr>
<td>Cultural Skills</td>
<td>2.73</td>
<td>0.33</td>
</tr>
<tr>
<td>Organizational Support for Multicultural Practice</td>
<td>2.52</td>
<td>0.43</td>
</tr>
</tbody>
</table>

*Note. SD = standard deviation.*
from those encountered in working with other groups. Thus, practitioners might find themselves adjusting their therapeutic strategies, trying different verbal and nonverbal communication strategies, and might grow to feel more confident in their cultural competency skills when practicing with African-American clients. Although we found no studies in the occupational therapy literature that specifically explored practice skills with African-Americans, Martin (1987) found that practitioners with multicultural experiences in practice rated themselves higher in cultural competence skills. In general, researchers have found that practitioners with experience working with multicultural populations tend to score themselves higher than those who do not have experience (Campinha-Bacote, 2003; Leninger, 2000). This study supports these statements. This finding does not mean that practitioners experienced in working with multicultural populations are necessarily more culturally competent than those who do not have experience. However, these practitioners may perceive themselves as competent because of their experience. More research needs to be conducted to discern the relationship between variables such as experience with multicultural populations, perceived level of cultural competence, and therapeutic outcomes for multicultural clients.

A high percentage of respondents agreed that cultural competence is an important core skill in their practice, and, overall, they felt culturally competent to address the needs of multicultural groups. The characteristics of the respondents in this study are similar to the overall characteristics of the national population of occupational therapists. Thus, the majority of respondents were White women with either a bachelor’s or master’s degree, practicing in school settings, nursing facilities, and rehabilitation centers.

Limitations

Two potential limitations of this study need to be considered: First, participants self-selected themselves by responding to the survey if they were interested in the topic or if they felt culturally competent. Thus, the findings should be interpreted with caution and awareness of potential sample bias. Second, the research study was conducted on a random sample of 1,000 AOTA members. Therefore, the results of the study may generalize to AOTA members but not to the whole population of U.S. occupational therapists.

Future Research

The fact that respondents rated the importance of cultural competence as a core skill needed in effective occupational therapy practice supports the more recent emphasis among researchers in the profession and calls for attention to this area of training and skill development (see Black & Wells, 2007; Bonder et al., 2004; Suarez-Balcazar et al., 2006; Suarez-Balcazar & Rodakowski, 2007; Wells & Black, 2000; Wilson, 2006). These researchers have called for attention to cultural competence and for a more careful examination of formal and informal training in occupational therapy programs that introduce and expose students and practitioners to issues of diversity and cultural competency. Research studies have found that health professionals often lack the cultural awareness, knowledge, skills, and organizational support to be effective in their practice (AOTA, 2005; Black & Wells, 2007).

This study also calls for attention to organizational practices that can either support or hinder cultural competency. Individual occupational therapists may be motivated and eager to modify and adapt their practices to minority populations, but agency and practice settings may have rigid guidelines—often dictated by reimbursement practices—that may preclude or inhibit innovation. Occupational therapy academic programs should prepare students for this issue: how particular clients may be excluded from certain services they cannot afford or for which no reimbursement is available. Given that many minority clients are also low-income earners, this issue has great relevance. More research in this area is recommended.

Future research should also examine the most effective ways to train practitioners in cultural competency and ways to enhance training opportunities and perhaps require continuing education credits for professional accreditation in cultural competency. There is also a need to survey occupational therapy programs throughout the country to examine how they teach cultural competency and the limitations and challenges they experience in teaching such core skills. Furthermore, research needs to establish empirical evidence that training in cultural competency results in better client outcomes. This is, in fact, one of the limitations of most of the studies in the area of cultural competence to date: the lack of evidence of a direct relationship between cultural competence and better client outcomes.

This study makes important contributions to the field of occupational therapy and has important implications for research, practice, and teaching. In terms of research, this study is the first to explore perceived levels of cultural competence in a random sample of occupational therapists in the United States using a validated instrument. In terms of practice, this study experimentally confirms the importance of cultural competence as a core skill needed for effective practice from the perspective of practitioners. Finally, this study confirms the importance of formal and informal training in cultural competency. As participants indicated, the more formal and informal training they had, the more culturally competent they rated themselves.

Occupational therapists, like most other health-related professionals, are under enormous pressure to adapt and
meet the changing demands and demographic characteristics of the general population. These include demands not only to overcome language and cultural differences because of migration and globalization but also to incorporate ever-changing new technologies. Professional training programs face the challenge of keeping students up to date with these demands, as do professional associations and certification boards. This study’s findings are encouraging because they point to professionals who feel confident in their capacity to serve diverse populations in a culturally competent way. At the same time, these professionals acknowledge the need to keep up with the country’s changing demographics. ▲

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